San Joaquin County
Behavioral Health Services

Mental Health Services Act (MHSA)

Revision of the Annual Update to the Three-Year Program and Expenditure Plan FY 2019/20

Revision Date: November 19, 2019

Board of Supervisors Approval: January 7, 2020

First Revision of the Mental Health Services Act (MHSA) Annual Update to the Three Year Program and Expenditure Plan FY 2019-20.

On August 24, 2019, the State of California Department of Health Care Services issued Information Notice MHSUDS 19-037, requiring counties to adjust their Prudent reserve Funding Level in accordance with Welfare and Institutions Code (W&I) Sections 5847 (b)(7) and 5892 (b) and (h).

For this reason, San Joaquin County Behavioral Health Services has revised its FY 2019-20 MHSA Annual Update to the Three Year Program and Expenditure Plan, originally posted for Public Review on May 15, 2019 and approved by the San Joaquin Board of Supervisors on June 11, 2019. This revised Annual Update will be posted for Public Review on November 19, 2019 and will be in effect upon approval of the Board of Supervisors. In addition to Prudent Reserve Funding information, the revision also includes minor edits and clarifications to projects and budgets as detailed below.

Summary of changes to 2019-2020 MHSA Plan Update

1. Funding Summary – CalMHSA and Prudent Reserve Pg. 26
    - Adjusted budget to comply with DHCS Information Notice 19-037 on Prudent Reserves.
    - Budget adjustment on assigned funds to CalMHSA

2. Clarify that the High Risk Transition Team is an Enhanced FSP
    - Minor edits were made on pages 36, 38, 44, 46 and 73

3. FSP Funds for Non-Mental Health Services and Supports - Pg. 42
    - Addition of clarification of available funds for FSP Non-Mental Health Services and Supports.

4. CSS Project 1 - MHSA Pathways FSP Team - Pg. 47-48
    - Clarifications on the Intensive FSP for Youth in the Dependency System and division of the project into two FSP's based on severity of illness.

5. CSS Project 16 – Project Based Housing - Pg. 89-91
    - Budget adjustment on the Project Based Housing Fund
    - Elimination of the requirement that residents of the project remain in a FSP for five years

6. System Development Expansion - Pg. 104
    - Budget adjustment on the expansion of core services

7. PEI Project 7 – Community Trauma Services for Adults Pg. 130-131
    - Staff clarifications on program activities for the project

8. MHSA Funds – Reduction of the Prudent Reserve Balance Pg. 170
    - Fiscal Worksheet on DHCS Information Notice 19-037

SAN JOAQUIN COUNTY

MHSA FISCAL ACCOUNTABILITY CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☐ Three-Year Program and Expenditure Plan

X Annual Update

☐ Annual Revenue and Expenditure Report

Local Mental Health Director		**County Auditor-Controller / City Financial Officer**	
Name:	Tony Vartan	Name:	Jay Wilverding
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Local Mental Health Mailing Address:			
1212 N. California St. Stockton CA 95202			

I hereby certify that the Three-Year Program and Expenditure Plan is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Tony Vartan, _____ VA _____ 12/20/2019.
Mental Health Director Signature Date

I hereby certify that for the fiscal year ended June 30, 2018, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, 2018. I further certify that for the fiscal year ended June 30, 2018, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Jay Wilverding, _____ Jay Wilverding _____ 12-23-19
County Auditor Controller Signature Date

SAN JOAQUIN COUNTY
MHSA COMPLIANCE CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☐ Three-Year Program and Expenditure Plan

X **Annual Update**

Local Mental Health Director		**Program Lead**	
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1212 N. California St. Stockton CA 95202			

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan, including stakeholder participation and non-supplantation requirements.

This Three-Year Program and Expenditure Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 11, 2019.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached to this Annual Update to the Three Year Program and Expenditure Plan are true and correct.

Tony Vartan, _____ _____ 12/20/19
Mental Health Director Signature Date

Table of Contents

I. Introduction

In 2004 California voters approved the enactment of the Mental Health Services Act (MHSA) for expanding mental health services to unserved, underserved, and inappropriately served populations in California to reduce the long-term impacts of untreated serious mental illness on individuals and families. The Act was amended and updated by the California Legislature in 2012 and 2016.

MHSA consists of five components, each focusing on a different aspect of the mental health system of care. These are:

- Prevention and Early Intervention (PEI),
- Community Services and Supports (CSS),
- Workforce Education and Training (WET),
- Innovation (INN), and
- Capital Facilities and Technological Needs (CFTN).

The MHSA requires the County to develop a MHSA Plan for each of the five components based on the funding allocation provided by the State and in accordance with established stakeholder engagement and planning requirements.

All MHSA component plans must address the needs of children and transitional age youth (TAY) with serious emotional disturbances or mental illnesses and adults and older adults with serious mental illnesses, as well as address specific needs related to cultural competency and in serving the needs of those previously unserved or underserved.

All MHSA plans and funded programs must operate in accordance with applicable guidelines and regulations, including the California Code of Regulations, Title 9, Chapter 14, Sections §3100 - §3865.

A Three-Year Program and Expenditure Plan for the period of FY 17/18, FY 18/19, and FY 19/20 was developed and approved by San Joaquin County Board of Supervisors in June 2017.

This Annual Update for FY 2019/20 represents the continuation of prior MHSA programs and strategies.

All San Joaquin County MHSA plans may be reviewed at www.sjcbhs.org.

MHSA Program Priorities

MHSA programs align with the mission, vision, and planning priorities established by San Joaquin County Behavioral Health Services in collaboration with its consumers and stakeholders.

Mission Statement

> The mission of San Joaquin County Behavioral Health Services is to partner with the community to provide integrated, culturally and linguistically competent mental health and substance abuse services to meet the prevention, intervention, treatment and recovery needs of San Joaquin County residents.

Vision Statement

> The vision of San Joaquin County Behavioral Health Services is to collaborate as a resilient team exploring changes, sharing ideas, striving to empower consumers, families, volunteers and care providers toward building hope, addressing disparities, and fostering wellness and recovery through individual strength-based treatment.

BHS Planning Priorities

II. Community Program Planning and Stakeholder Process

Community Program Planning Process

The community planning process serves as an opportunity for consumers, family members, mental health and substance abuse service providers and other interested stakeholders to discuss the needs and challenges for consumers receiving mental health services and to reflect upon what is working for the diverse range of consumers served. The following activities were conducted to gather information regarding current services and to provide recommendations on the need for updates and revisions.

Quantitative Analysis:

- BHS Program Service Assessment: September – March
  - Utilization Analysis
  - Penetration and Retention Reports
  - External Quality Review
- Workforce Needs Assessment
- Evaluation of Prevention and Early Intervention Programs for 2017/18

Community Discussions:

- MHSA Showcase of Programs and Services
  - October 10, 2018
- Behavioral Health Board:
  - October 2018 – Discussion of Homelessness, Housing, and the Mentally Ill
  - November 2018 – MHSA, Community Planning Meeting
- General Public Forums
  - November 5, 2018 at Behavioral Health Services in Stockton, CA
  - November 7, 2018 at the Larch Clover Community Center in Tracy, CA
  - November 8, 2018 at the Lodi Public Library in Lodi, CA

Targeted Discussion Groups

- Consumer Focus Groups
  - November 8, 2018 at the Wellness Center
  - November 15, 2018 at the Martin Gipson Socialization Center
- Consortium of MHSA Providers and Stakeholders
  - December 5, 2018

Consumer and Family Member Surveys

- 2018-19 MHSA Youth or Family Member of Children and Youth Survey
- 2018-19 MHSA Adult consumer Survey

Assessment of Mental Health Needs

Population Served

San Joaquin County Behavioral Health Services (BHS) provides behavioral health services, including mental health and substance use disorder treatments to nearly 15,900 consumers annually. In general program access is reflective of the diverse population of San Joaquin County; with a roughly even division of male and female clients. An analysis of services provided in fiscal year 2017-18, provides a general overview of program participation and county population.

Mental Health Services provided FY 2017-18

Services provided by Age	Number of BHS Clients*	Percent of BHS Clients
Children	3022	19.0%
Transitional Age Youth	3087	19.5%
Adults	8104	51.0%
Older Adults	1661	10.5%
Total	**15,874**	**100%**

*Source: BHS Client Services Data

Program participation is reflective of anticipated demand for services, with the majority of services being delivered to adults, ages 25-59 years of age. The participation amongst other age groups is consistent with their percentage within the total population.

Race/Ethnicity	County Population by Race/Ethnicity*	Percent of County Population		Clients Served by BHS	Percent of BHS Clients
White	235,440	32%		5,908	37%
Latino	310,067	42%		4,086	26%
African American	50,693	7%		2,953	19%
Asian	111,968	15%		1,642	10%
Other	31,932	4%		745	5%
Native American	1,337	0%		479	3%
Pacific Islander	3,987	1%		61	0%
Total	**745,424**	**100%**		**15,874**	**100%**

*Source: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/

Diversity of participants is similar to the distribution in prior years. African Americans are disproportionately over-represented amongst consumers compared to their proportion of the general population (19% of participants, though comprising 7% of the population of the County). Native Americans are also over-represented within the service continuum (3% of clients are Native American) and data indicates that nearly one-third of the Native American's in the County received services from

BHS at least one time during the past year. Latinos are enrolled in mental health treatment services at rates lower than is be expected compared to their proportion of the general population (26% of participants though comprising 42% of the population). Participation amongst children and youth is more reflective of the racial demographics of the overall population, with over a third of services provided to young Latinos (35%), suggesting that while stigma, language or cultural barriers, or access to health care services continue to impede access for Latino adults with behavioral health needs more services are reaching the younger populations.

City	County Population by City*	Percent of County Population		Clients Served by BHS	Percent of BHS Clients
Stockton	315,103	42%		10,591	67%
Lodi	67,121	9%		1,313	8%
Tracy	92,553	12%		966	6%
Manteca	81,345	11%		1,000	6%
Lathrop	24,268	3%		282	2%
Ripon	15,847	2%		107	1%
Escalon	7,558	1%		89	1%
Balance of County	154,949	20%		1,526	10%
Total	**758,744**	**100%**		**15,874**	**100%**

*Source: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/

The majority of clients are residents of the City of Stockton. Stockton is the County seat and largest city in the region, accounting for 42% of the county population. The majority of services and supports for individuals receiving public support benefits (including mental health) are located in Stockton.

Discussion Group Input and Stakeholder Feedback

Several different types of community forums and discussion groups were convened in the Fall of 2018 to provide opportunities for a range of community stakeholders to participate in the Community Program Planning Process.

Community Program Planning for 2019-20 began in October 2018. The first set of activities included

1. MHSA Showcase.

   The purpose of the MHSA Showcase was to provide a venue for consumers, family members, stakeholders and interested community members to learn more about the programs and services funded in San Joaquin County through MHSA Program funds. The Showcase Event featured individual program booths for all MHSA funded programs – both those operated by BHS as well as those managed by contracted community partners.

The MHSA Planning Booth at the Showcase included a poster and flyer of upcoming community planning meetings and included surveys, comment cards, and additional information about how to participate in the Community Program Planning Process.

2. Announcement at the October 2018 Behavioral Health Board

   An announcement was made during the public comments portion of the October Behavioral Health Board Meeting that community program planning discussion groups were convening in November. The Director's Report included additional details regarding the proposed methodology and timeline for the community program planning process conducted to inform the 2019/20 Annual Update to the Three Year Program and Expenditure Plan. Meeting flyers for upcoming Community and Consumer Discussion Groups were distributed.

Community and Consumer Discussion Groups were held during the first two weeks of November and included three community forums and two groups specifically targeting participation by consumers ages 18 and older. The final Community Discussion Group was held in conjunction with the Behavioral Health Board Meeting, providing an opportunity for stakeholders to directly provide input to the members of the Behavioral Health Board.

All community discussion groups begin with a brief training on the Mental Health Services Act, a summary of the five components, and information about the intent and purpose of the different components including:

- Funding Priorities
- Populations of Interest
- Regulations guiding the use of MHSA funding

Stakeholder participation at these groups was tracked through meeting sign-in sheets and through the collection of anonymous demographic forms. Findings from the Demographic Form suggest that a diverse group of stakeholders participated in the community program planning process, including representatives of unserved and underserved populations.

One hundred and seventy-one individuals (N=171) participated in the community meetings and focus groups. Of these over half, (N=57%) self-identified as a consumer of public mental health services or as a family member of a consumer. The majority of participants identified as adults ages 26-59 however 22% were older adults and 5% were youth ages 18-25.

Community Meetings were also attended by the following types of individuals:

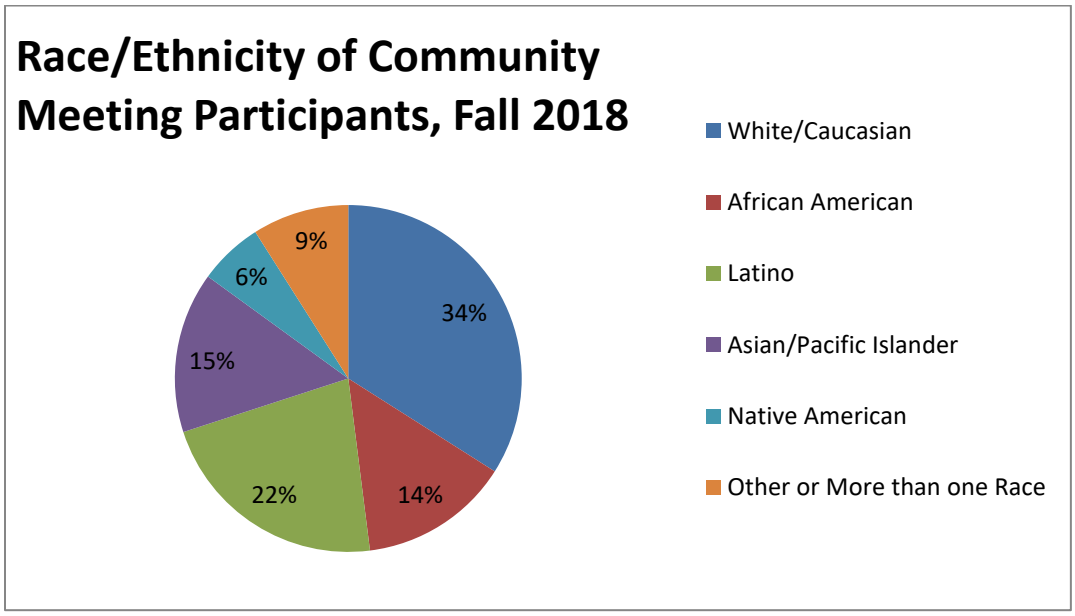
- County mental health department staff
- Substance use disorder treatment provider
- Community-based organization staff
- Children and Family Services
- Law Enforcement

- Veterans Services
- Senior Services
- Housing Providers
- Health care Providers
- Advocates for people with Serious Mental Illness

Community meetings included a diverse array of stakeholder participants. Sixteen percent (16%) of meeting participants reported speaking a language other than English at home; this compares favorably to the overall BHS population served during FY 2017/18, in which 13% of clients served spoke a language other than English.

This year also saw a greater proportion of individuals self-identifying as transgender (n=4) than in previous years which typically only included one or two individuals self-identifying as transgender. It is unknown if these increases are due to improved outreach efforts or due to community-wide reductions in stigma allowing more people the safety to self-disclose.

Community meetings were attended by a broad range of individuals representing diverse racial/ethnic backgrounds. Similar to the County population and BHS services, no one racial or ethnic group comprised a majority of participants. Also, in line with BHS service delivery patterns, there was a slight overrepresentation of African American participants, compared to the County population, and a slight underrepresentation of Latinos. These rates are consistent with service utilization at BHS.



Survey Input and Stakeholder Feedback

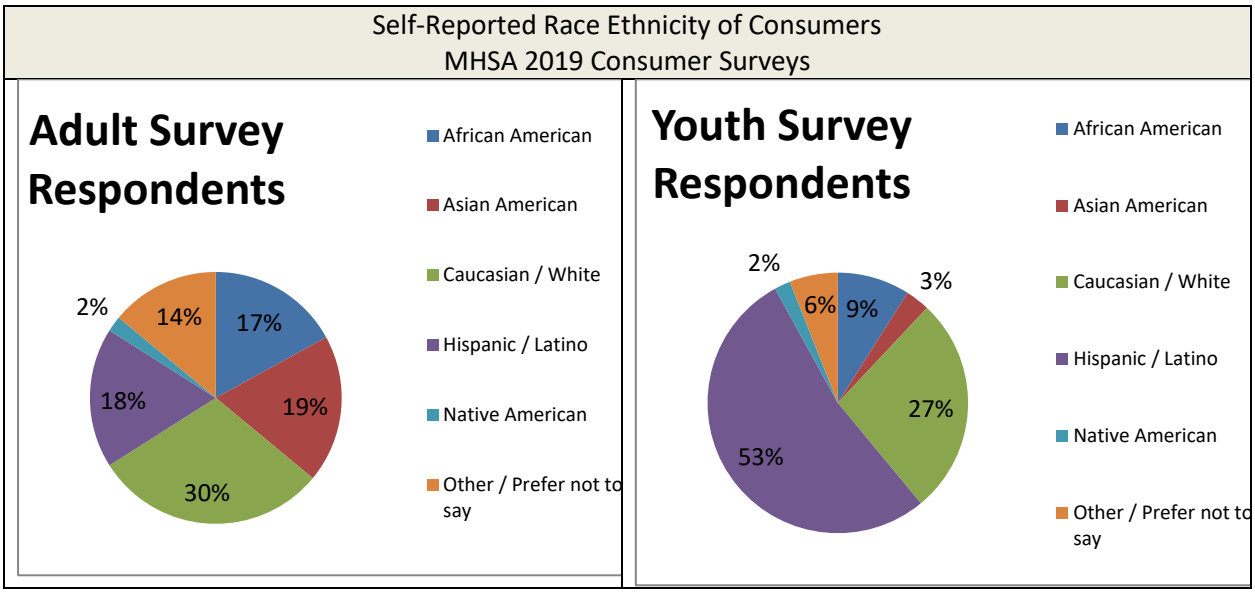
BHS distributed two surveys to consumers and family members in January 2019 to learn more about the perspectives, needs, and lives of the clients served through mental health programs. Over 800 individuals completed the surveys. The ***MHSA Adult Consumer Survey*** was distributed through BHS Crisis Services and various Outpatient Clinics; 501 adults completed this survey. An additional 335 family members or youth completed the ***MHSA Youth or Family Member of Children and Youth Survey*** in conjunction with services received through BHS Children and Youth Services. Survey questions were relatively the same across both questionnaires, with slight differences in the phrasing of the questions depending on the target audience. Surveys were paper-based surveys with limited choice answers. Responses were scanned into a software program that uses a proprietary technology to match checked answers with corresponding data fields. Survey instruments can be reviewed in the Appendix.

Overall BHS consumers and their family members report high levels of satisfaction with the services provided to address mental health and/or substance use disorder concerns with 85% of the respondents reporting that they would recommend BHS services for others. In terms of challenges, respondents from both surveys reported that the greatest service challenge is the length of time it takes to get an appointment. Satisfaction for all respondents was highest in the area of thoroughness of services provided. In terms of cultural competency respondents of both surveys reported that the more work is needed to make the lobbies and reception areas feel welcoming and friendly; but report the highest levels of agreement with statements regarding staff courtesy and professionalism, respect of cultural heritage, and capacity to explain things in an easily understood manner. In one area of discrepancy between the respondents, consumers in the adult system of care were far more likely to describe BHS interpretation services as needing improvement than those served in the children and youth system of care (amongst those that have ever used interpretation services). Within the children and youth system, 92% of respondents described interpretation services as good or better, vs. only 76% of those served in the adult system of care. More work is needed to understand this discrepancy as BHS has just one set of protocols to respond to interpretation needs of clients, regardless of the system of care.

BHS was also interested in learning more about the types of people that use mental health services and used the survey tool as a way to ask clients to anonymously self-report demographic information, in the hope of getting a more nuanced understanding of the clients served separate from the data stored and reported in standardized intake forms. Survey data revealed interesting findings about client demographics, criminal justice experiences, and living situations that has not been consistently reported elsewhere.

Race/ethnicity data for the two surveys is depicted below. Race/ethnicity data is reflective of the BHS client population. Notably children and youth are more likely to be Hispanic /Latino than adult survey respondents. Adult survey respondents were more likely to be African American, Asian, or Native American than is reflective of the general population. Again, this aligns with the population served by BHS.

More detailed summaries for each population subset follows.



Summary of Adult Consumer Demographic Data (as self-reported on the survey) N=501

Age Range	Percent
18-25	11%
26-59	63%
60 and over	23%
Other or decline to state	3%

Gender	Percent
Male	42%
Female	56%
Non-binary	1%
Transgender	1%

The 500 Adult consumers surveyed represent the broad diversity of clients served by Behavioral Health Services. Most consumers have children, with 55% describing themselves as parents. Consistent with the general population, 11% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQQI). Many have a disability, with 48% describing themselves as having a physical or developmental disability. Few are military veterans, with only 6% reporting that they had served in the US armed forces. Finally a quarter of clients reported experiencing homelessness more than four times or being homeless for a at least a year (25%); and a significant portion (40%) reported having been arrested or detained by the police.

Summary of Children and Youth Consumer Demographic Data (as self-reported or declared by a parent or guardian on the survey) N=335

Age Range	Percent
0-5	5%
6-11	29%
12-15	31%
16-21	17%
22-25	7%
Prefer not to say	10%

Gender	Percent
Male	33%
Female	60%
Non-binary	0%
Transgender	1%
Prefer not to say	5%

The child's parent or guardian completed approximately half of the Children and Youth Surveys. Parents were instructed to complete surveys from the perspective of their child, but there may be some error in asking parents to complete surveys on behalf of their children. Amongst children and youth 12% self-identified at LGBTQQI and 24% reported having a disability. Veteran status was not asked on the children and youth survey. Children and youth served by Behavioral Health Services also face challenges with their living situation and in their interactions with the criminal justice system; several had been homelessness (n=31) or been detained by the police (N=40).

Community Mental Health Issues

Key Issues for Children and Youth

Strengthening services and supports for children, youth and their families remains a major concern in San Joaquin County. Stakeholders recognize the increase coordination between Behavioral Health Services and Child Welfare Services in addressing the needs of children and youth touched by the foster care system, but argue that more needs to be done to support and strengthen families, particularly those where risk factors for mental illness are present. In several of the community meetings convened, stakeholders discussed the importance of uniform screening processes and earlier interventions for children and families.

- Early Education providers and schools appear to be doing a sufficient job at conducting early screening and detection for social emotional concerns among young children. However additional work is needed to engage family practice physicians and pediatricians in identifying children and families in need of additional support services.
- The biggest gap in services are early interventions for children and families following the identification of a social-emotional risk factor. Schools are seeking more behavioral health consultations in the classroom to assist teachers in working with students (including pre-school age students) that are displaying behaviors suggestive of an emerging emotional disorder.
- Many stakeholders also identified family supports such as parenting classes, family strengthening activities, and family peer partners as being pivotal early interventions to help empower parents, stabilize families, and reduce tension/anxiety among children. In particular, stakeholders suggested targeting resources towards (1) parents with self-identified behavioral health concerns of their own, and (2) young parents, particularly young parents with more than one child under 5 in the home.

Recommendations to Strengthen Services for Children and Youth:

- All adults, with children in the home, who are receiving services from BHS Adult Outpatient Clinics should be offered services or supports pertaining to family strengthening; and referred to PEI funded parenting classes.
- BHS should work with San Joaquin Child Welfare Services to review case files of young families with multiple children under 5 in the home; offer parenting classes, services, or supports;

engage families and make referrals to existing parenting classes funded through PEI programming.

- The PEI school-based interventions program providing behavioral health interventions on school campuses should be available to all children, including those in pre-school or transitional kindergarten programs.

Key Issues for Transitional Age Youth

In general, stakeholders expressed the most concern for transition age youth who are easily missed by system partners – including those that have been in the military, have exited the foster care system, are college age, or are from communities that are historically unserved or underserved by mental health services. Stakeholders identified some existing resources for transition age youth, but overall stated that outside of a few specialty treatment programs, most interventions target either children and youth, or adults. Despite these gaps, stakeholders remain optimistic that current resources can be leveraged in a better way to serve transitional age youth.

- Both UOP and Delta College have student mental health programs. However, programs are not well articulated to off-campus services and supports, especially those available through the primary health care system to address mild to moderate behavioral health concerns. More linkages and articulating are needed to prevent the escalation of illnesses that can benefit from early interventions such as depression and anxiety.
- Numerous partners are working to reach returning veterans, and new services such as the veteran's court are identifying at-risk veterans and engaging them into services and supports, including alcohol and drug treatment programs.
- Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, or allied youth were also identified as being at higher risk for untreated behavioral health concerns, including using alcohol of other substances as a coping mechanism for depression or anxiety related to social stigma and discrimination towards their sexual identity. LGBTQI youth have few resources or supports in San Joaquin County, though an emerging allies movement is increasing awareness of the need for more deliberate and integrated approaches to supporting LGBTQI youth in San Joaquin county.

Recommendations to strengthen services for transition age youth 16-25

- More and more apps for smart devices are emerging on the marketplace. Solicit the assistance of young people to identify which apps and tools that are being used to support mindfulness, wellness, and mental health.
- Work with local colleges to develop a pathway for referrals for student mental health concerns. Convene workshop for college mental health professionals on the prevention and early interventions services available in the community and tips for accessing mental health interventions for mild to moderate behavioral health concerns.
- Work with Veterans Services to support young adults exiting the military and returning to San Joaquin County. Convene workshops for veterans services counselors in the prevention and

early interventions services available in the community and tips for accessing mental health interventions for mild to moderate behavioral health concerns.

- Develop smart graphics poster, in English and local threshold languages, which provides navigation guidance and advice in accessing behavioral health services for self or friends. Include risk for suicide ideation, and suicide ideation through gun violence.
- In 2017/18 BHS reserved funding for programs to address the behavioral health needs of transition age youth and adults experiencing or recovering from traumatic situations. Program services for Transitional Age Youth should demonstrate capacity for delivering culturally competent and trauma informed services, including services for transition age youth who do not have English as a first language, and for youth that are especially vulnerable to stigma, discrimination, and marginalization such as LGBTQI youth.

Key Issues for Adults

Consumers and community allies discussed the challenges of being homeless while seeking recovery from a mental illness and the need to develop more housing opportunities for people with mental illnesses. Criminal justice partners played an active role in the community program planning meetings and echoed the frustrations of consumers and family members regarding the need for better housing options to avert homelessness. Consumers also expressed frustration that it is still difficult to find reliable information on the services and supports that are available and asked BHS to consider different approaches to talking about mental health and the services available in the community.

- Too many clients are homeless and/or justice involved. BHS needs to work collaboratively to develop comprehensive treatment approaches to prevent the criminalization of the mentally ill. This should include a focus on strengthening services for those dually diagnosed with both a mental illness and a substance use disorder.
- Individuals with mental illnesses, who have been arrested and charged with offenses, are at high risk of homelessness and re-offending upon re-entry in the absence of coordinated services and supports. More efforts are needed to strengthen re-entry services for people with serious mental illnesses to avert homelessness and prevent decompensation from an untreated illness. More coordination is needed to assess all individuals exiting custody for mental illnesses and link them to existing community services prior to release.
- More information is needed regarding access to services. Public information messages should be tailored for consumers, family members, and partner service providers. Information should be developed that is responsive to diverse cultural communities – understanding that clients come from diverse backgrounds and have a range of experiences – many are parents, many are LGBTQ, and many have a first language other than English.
- More education is needed regarding mental health in general. Veterans and Latino communities are underrepresented in the adult mental health service system. Education is needed to reduce stigma towards mental illness that may prevent help seeking behavior. Education is also needed to address suicide risk and ideation – especially targeting adult men.

- BHS should work with community partners to better serve Southeast Asian clients as there is low language proficiency among BHS staff to serve some Southeast Asian clients in their native languages. BHS has 42 staff that are proficient in Tagalog, 8 who are proficient in Hmong, and 4 who are proficient in Cambodian. However there are no direct service staff that are proficient in either Laotian or Vietnamese.

Recommendations to strengthen services for Adults.

- Continue to strengthen the housing continuum for people with serious mental illnesses.
- Strengthen outreach and engagement to underserved populations including Latinos and military veterans. Consider adopting new public information and education strategies that are more broadly received and more specifically target stigma and discrimination.
- Expand suicide prevention efforts (beyond school-based prevention efforts). Develop public information and education campaign for adults with a focus on adult men and veterans.
- Create more treatment teams or residential programs that work specifically with individuals diagnosed as having co-occurring disorders.

Key Issues for Older Adults

Older adults with mild to moderate mental health concerns remain at-risk for untreated depression and suicide ideation. More articulation is needed with senior centers and other programs serving older adults to provide specialty interventions for older adults that have escalating behavioral health challenges. More public information and education about the risk of suicide in adults and older adults is also needed; particularly focusing on adult men who are at the highest risk for suicide in San Joaquin County. Stakeholders identify increase use of alcohol as a coping mechanism for depression and suggest that behavioral health programming should be (1) better targeted to older adults, (2) more urgently address alcohol and depression as co-morbid conditions, (3) provide meaningful alternatives for daily living that combat depression and isolation including more socialization activities and more activities that prevent memory deterioration or loss of cognitive functioning. Finally stakeholders identified the biggest risk to be among older adults living independently and who are socially isolated. Community members in the Tracy area stated that there are few resources for older adults in South County. The director of the Larch Clover Community Center in Tracy, which hosted the meeting, encouraged more behavioral health services being co-located at local community centers which provide arrange of senior activities, services, and supports in locations throughout the County.

- There are few behavioral health prevention services for older adults in San Joaquin County.
- There are few evidence based substance use disorder treatment programs designed for older adults in San Joaquin County, this is of serious concern because alcohol abuse is strongly correlated with older adult depression.
- Expanded prevention services should work in partnership with local community centers.
- Vulnerable older adults include those that are homeless (which account for 10% of the total homeless population) and those that are isolated and living alone.

Recommendations to strengthen services for Older Adults:

- Co-locating senior peer counseling program in local community centers one day a week to provide information on the mental health services and supports available to older adults in the community. Ensure that senior peer partners have training in recognizing signs and symptoms of alcohol abuse and have an array of tools and resources to offer older adults requesting assistance with behavioral health concerns, including co-occurring disorders.
- Work with Adult Protective Services to identify older adults with escalating mental health symptoms. Convene workshops for Adult Protective services counselors in the prevention and early interventions services available in the community and tips for accessing mental health interventions for mild to moderate behavioral health concerns.
- Strengthen and enhance suicide prevention efforts to target the entire community. Include targeted prevention information for middle age and older adult men. Include a focus on handguns and firearm safety precautions when living with loved ones experiencing depression.

III. Public Review of Revised Plan

Dates of the 30 day Review

The revision document was posted for review and circulation on the San Joaquin County Behavioral Health Services website on November 19, 2019. The public review closes on December 18, 2019.

Comments are accepted via e-mail to: mhsacomments@sjcbhs.org

Or via postal mail to:

San Joaquin County Behavioral Health Services
Attn: MHSA Planning Coordinator
1212 N. California St.
Stockton CA, 95202

Methods of Circulation

E-mail notices were sent to all members of the BHS MHSA e-mail list, which has been compiled and updated continuously since MHSA planning began in 2006. Contracted providers are asked to post notifications in their public program areas that the draft plan was available for review. The plan was posted for review on the San Joaquin MHSA website at:

www.sjcbhs.org/mhsa/mhsaplan

Public Hearing

December 18, 2019
5:00pm – 7:00pm
Manteca Library
320 West Center Street
Manteca, CA 95336

A Public Hearing was held on Wednesday, December 18, 2019 in conjunction with a regularly scheduled Behavioral Health Board Meeting.

The Public Hearing began with the brief presentation of the summary of changes to the revised Annual Update. The presentation concluded with the time and dates of the upcoming presentation to the Board of Supervisors.

There were no substantive comments during the public hearing.

The San Joaquin County Board of Supervisors reviewed and approved the FY 2019-20 Revision to the Annual Update on: January 7, 2020.

Before the Board of Supervisors

County of San Joaquin, State of California

B-20-18

Approval of 2019-2020 Revised Annual Update to the Mental Health Services Act Program and Expenditure Plan Totaling 59,006,566

THIS BOARD OF SUPERVISORS DOES HEREBY approve the 2019-2020 Revised Annual Update to the Mental Health Services Act Program and Expenditure Plan totaling $59,006,566.

I HEREBY CERTIFY that the above order was passed and adopted on January 7, 2020 by the following vote of the Board of Supervisors, to wit:

MOTION: Villapudua/Winn/5

AYES: **Villapudua, Patti, Winn, Elliott, Miller**

NOES: **None**

ABSENT: **None**

ABSTAIN: **None**

ATTEST: RACHÉL DeBORD
Clerk of the Board of Supervisors
County of San Joaquin
State of California

Rachél DeBord

III. Public Review of Original Plan

Dates of the 30 day Review

The document was posted for review and circulation on the San Joaquin County Behavioral Health Services website on April 12, 2019. The public review closes on May 15, 2019.

Comments were accepted via e-mail to: mhsacomments@sjcbhs.org

Or via postal mail to:

San Joaquin County Behavioral Health Services
Attn: MHSA Planning Coordinator
1212 N. California St.
Stockton CA, 95202

Methods of Circulation

E-mail notices were sent to all members of the BHS MHSA e-mail list, which has been compiled and updated continuously since MHSA planning began in 2006. Contracted providers were asked to post notifications in their public program areas that the draft plan was available for review. The plan was posted for review on the San Joaquin MHSA website at:

www.sjcbhs.org/mhsa/mhsaplan

Public Hearing

May 15, 2019
5:00pm – 7:00pm
1212 N. California St.
Conference Rooms B & C
Stockton, CA 95202

A Public Hearing was held on Wednesday May 15th 2019 in conjunction with a regularly scheduled Behavioral Health Board Meeting.

The Public Hearing began with a brief presentation of the Annual Update, its purpose and the public planning process used to inform the Annual Update. The presentation also included a summary of significant changes (new programming) created through the plan and an overview of the long term financial projections for MHSA funds. The presentation concluded with the time and dates of the upcoming presentation to the Board of Supervisors and updates about the launch of the next community program planning process for the upcoming Three Year Program and Expenditure Plan.

The San Joaquin County Board of Supervisors will review the FY 2019-20 Annual Update on June 11, 2019.

Substantive Comments

Overall there was strong support at the public hearing for the two new projects and additional updates described in this Annual Update. Comments included the following suggestions and observations:

- Appreciations for expanding efforts to address stigma and discrimination (PEI project number 11): Comment – please consider leveraging the local NAMI chapter which has a lot of experience in this area and does a lot of work to reach into the community and with schools to reduce stigma and discrimination.
- Appreciations for linking the Intensive Justice FSP program to a collaborative program with criminal justice partners for a pre-trial felony mental health diversion program. Comment – please make sure to provide interventions using the full service partnership model with a very intensive service delivery model.
- Comment: Throughout the country there is a crisis of epic proportions associated with homelessness among those with co-occurring disorders. We are doing a lot in San Joaquin County to respond, but a larger investment and more strategic approach is needed at the federal level.
- Comment: More people need to be part of the process. Appreciate that many people came to meetings to talk about needs, but sometimes it seems as if people only care about the issues facing those with mental illnesses when there is money on the table.
- Question: To what extent are the new PEI projects sustainable? Response: Both of the new PEI Projects (Information and Education Campaign and the community-wide Suicide Prevention and Awareness Campaign) are scoped as short-term, time limited projects to develop and implement a new communications strategy to increase awareness of and reduce stigma and discrimination towards mental health concerns. Projects continue to meet sustainability goals.

Additionally the public hearing included a description of the following minor edits made to the Annual Update during the 30-day review process:

- Typos, Formatting
- Staff clarifications on program activities
- A budget adjustment to provide match funds for a state grant

A copy of the public presentation is included in the Appendix.

IV. MHSA Component Funding for FY 2019-20

MHSA Component Worksheets describe the total planned expenditures for Fiscal Year 2019-20.

1. Summary Worksheet
2. Community Services and Support Worksheet
3. Prevention and Early Intervention Worksheet
4. Innovation Worksheet
5. Workforce Education and Training Worksheet
6. Capital Facilities and Technological Needs Worksheet

FY 2019/20 Mental Health Services Act Annual Update
Funding Summary

County: San Joaquin County

Date: 11/19/19

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	15,314,327	10,660,179	8,439,714	15,000	3,040,474	
2. Estimated New FY 2019/20 Funding	25,396,145	6,349,464	1,671,272			
3. Transfer in FY 2019/20[a/]	(5,590,269)			403,994	5,186,275	0
4. Access Local Prudent Reserve in FY 2019/20						
5. Estimated Available Funding for FY 2019/20	35,120,203	17,009,643	10,110,986	418,994	8,226,749	
B. Estimated FY 2019/20 MHSA Expenditures	32,663,665	15,727,442	3,685,506	403,994	6,525,959	
G. Estimated FY 2019/20 Unspent Fund Balance	2,456,538	1,282,201	6,425,480	15,000	1,700,790	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	11,794,245
2. Contributions to the Local Prudent Reserve in FY 2018/19	0
3. Distributions from the Local Prudent Reserve in FY 2018/19	(166,836)
4. Estimated Local Prudent Reserve Balance on June 30, 2019	11,627,409

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2019/20 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: San Joaquin Date: 11/19/19

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children and Youth FSP	6,187,368	4,185,640	1,023,683		977,085	960
2. Transitional Age Youth FSP	855,879	556,410	298,109		1,360	
3. Adult FSP	10,254,142	4,951,318	5,275,843		281	26,700
4. Older Adult FSP	1,328,181	840,749	482,182			5,250
5. Community Corrections FSP	1,534,037	1,109,575	423,122			1,340
6. InSPIRE FSP	723,620	593,998	129,622			
7. Community Trauma Services for Adults FSP	1,500,000	1,500,000				
8. Intensive Justice Response FSP	1,500,000	1,500,000				
9. Housing Empowerment Services FSP	622,869	622,869				
10. High-Risk Transition Team	720,000	720,000				
11. Adult Residential Treatment Services	1,000,000	1,000,000				
Non-FSP Programs						
12. Mental Health Outreach and Engagement	504,317	504,317				
13. Mobile Crisis Support Team	1,332,876	863,826	151,396			317,654
14. Peer Navigation	300,000	300,000				
15. Wellness Center	519,403	519,403				
16. Project Based Housing	4,150,000	4,150,000				
17. Employment Recovery Services	197,372	197,372				
18. Community Behavioral intervention Services	796,288	510,261	284,427			1,600
19. Housing Coordination Services	2,163,429	2,163,429				
20. Crisis Services Expansion	4,484,369	1,458,311	2,968,058			58,000
21. System Development Expansion	1,352,803	981,733	371,070			
CSS Administration	4,384,382	3,434,454	949,928			
Total CSS Program Estimated Expenditures	46,411,335	32,663,665	12,357,440	0	978,726	411,504
FSP Programs as Percent of Total	56.5%					

FY 2019/20 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: San Joaquin Date: 11/19/19

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention Programs for Children, Youth & Families						
1. Skill Building for Parents and Guardians	479,102	479,102				
2. Family Therapy for Children and Youth	785,291	785,291				
3. Mentoring for Transitional Age Youth	860,305	860,305				
Early Intervention Programs for Children and Youth						
4. Early Mental Health Services	2,396,811	1,530,987	850,703		9,621	5,500
5. School Based Interventions	2,914,259	2,914,259				
6. Early Interventions to Treat Psychosis	996,771	314,133	682,538			100
Early intervention Programs for Adults and Older Adults						
7. Trauma Services for TAY, Adults and Older Adults	1,200,000	1,200,000				
8. Recovery Services for Victims of Human Trafficking	712,332	712,332				
9. Recovery Services for Nonviolent Offenders	472,706	472,706				
10. Forensics Access and Engagement	600,000	600,000				
Access and Linkage to Treatment Program						
11. Whole Person Care Project	894,136	383,009				511,127
Outreach for Increasing Recognition of the Early Signs of Mental Illness						
12. Increasing Recognition of Mental Illnesses	75,000	75,000				
Stigma and Discrimination Reduction Program						
13. Information and Education Campaign	1,739,130	1,739,130				
Suicide Prevention Program						
14. Suicide Prevention with Schools	592,248	592,248				
15. Suicide Prevention Awareness Campaign	652,174	652,174				
PEI Administration	2,199,225	2,199,225				
PEI Assigned Funds						
Funds assigned to CalMHSA	217,541	217,541				
Total PEI Program Estimated Expenditures	17,787,031	15,727,442	1,533,241	0	9,621	516,727

FY 2019/20 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: San Joaquin Date: 11/19/19

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Assessment and Respite Center	2,197,177	2,197,177				
2. Progressive Housing	1,449,808	1,449,808				
	0					
	0					
	0					
	0					
INN Administration	38,521	38,521				
Total INN Program Estimated Expenditures	3,685,506	3,685,506	0	0	0	0

FY 2019/20 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: San Joaquin Date: 11/19/19

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	351,299	351,299				
	0					
	0					
	0					
	0					
WET Administration	52,695	52,695				
Total WET Program Estimated Expenditures	403,994	403,994	0	0	0	0

FY 2019/20 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: San Joaquin Date: 11/19/19

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Residential Treatment Facilities for COD	2,434,786	2,434,786				
2. Facility Renovations	1,935,173	1,935,173				
3. Facility Repair and Upgrades	1,243,000	1,243,000				
	5,612,959	5,612,959				
CFTN Programs - Technological Needs Projects						
4. Digital Health Management Solutions	913,000	913,000				
	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	6,525,959	6,525,959	0	0	0	0

V. Community Services and Supports

Essential Purpose of Community Services and Supports Component Funds

The Mental Health Services Act (MHSA) allocates funding for Community Services and Supports (CSS) programs that provide treatment and interventions with individuals with serious mental health illnesses who meet the criteria for specialty mental health care services.

"Community Services and Supports" means the component of the Three-Year Program and Expenditure Plans that refers to service delivery systems for mental health services and supports for children and youth, transition age youth, adults, and older adults. These services and supports are similar to those found in Welfare and Institutions Code Sections 5800 et. seq. (Adult and Older Adult Systems of Care) and 5850 et. seq. (Children's System of Care). *CA Code of Regulations §3200.080*

In San Joaquin County funding will support:

1) Full Service Partnership Programs – to provide all of the mental health services and supports necessary to an individual who is unserved, underserved, and experiencing homelessness, justice involvement, or other indicator of severe unmet need (see eligibility criteria below.)

2) Outreach and Engagement Programs – to provide outreach and engagement to people who may need specialty mental health services, but are not currently receiving the care they need or are only receiving episodic or crisis mental health services.

3) General System Development Programs- to improve the overall amount, availability, and quality of mental health services and supports for individuals who receive specialty mental health care services.

The Mental Health Services Act is intended to expand and enhance mental health services to reduce the long-term adverse impacts on individuals and families resulting from untreated serious mental illness. The Community Services and Supports component of the Act, improves *outreach and engagement* to ensure that more individuals are successfully engaged in specialty mental health care services to reduce the incidence of untreated serious mental illness; *full service partnership programs* improve the quality and intensity of specialty mental health services for the most seriously ill and gravely disabled individuals that are experiencing negative outcomes associated with incarceration, homelessness, and prolonged suffering; and *system development projects* expand and enhance the entire specialty mental health system of care to better address the needs of all individuals diagnosed with serious mental illnesses or serious emotional disorders.

Full Service Partnership Program Regulations

BHS provides a range of community-based specialty mental health services to support consumers and family members. Individuals with a mental health diagnosis may be served at various levels within the continuum of care depending upon their treatment needs. Full Service Partnership Programs are offered to consumers who require the highest level of treatment interventions to achieve their recovery goals and who meet the Full Service Partnership eligibility criteria.

"Full Service Partnership Service Category" means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plans, under which the County, in collaboration with the client, and when appropriate the client's family, plans for and provides the full spectrum of community services so that children and youth, transition age youth, adults and older adults can achieve the identified goals. *CA Code of Regulations §3200.140*

"Full Spectrum of Community Services" means the mental health and non-mental health services and supports necessary to address the needs of the client, and when appropriate the client's family, in order to advance the client's goals and achieve outcomes that support the client's recovery, wellness and resilience. *CA Code of Regulations §3200.150*

The summary of the FSP eligibility criteria and FSP component services are described below.

1. FSP Eligibility Criteria

All individuals referred to, and receiving, FSP Program Services must meet the eligibility criteria for enrollment in a FSP as described by state statute, regulation, and local priority needs. Individuals enrolled in a FSP program will be reassessed every six months to ensure eligibility criteria remain current. Individuals that no longer meet the eligibility criteria and have stabilized in their treatment plan will be transitioned to more appropriate mental health services.

Criteria 1: Eligibility for Public Mental Health Services (WIC § 5600.3)

All individuals enrolled in a Full Service Partnership program must meet the criteria for specialty mental health services as defined by the California Welfare and Institutions Code.

Children and Youth (0-17)	Adults (18 and older)
Have a primary diagnosis of a mental disorder which results in behavior inappropriate to the child's age, and • As a result, has substantial impairment, *and* o Is at risk of removal from the home, *or* o The mental disorder has been present for more than 6 months and is likely to continue for more than a year if untreated. OR The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.	Have a primary diagnosis of a serious mental disorder which is severe in degree, persistent in duration, and which may cause behavioral functioning that interferes with daily living. • Mental disorder, diagnosed and as identified in Diagnostic and Statistical Manual of Mental Disorders. • As a result of the mental disorder, the person has substantial functional impairments • As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements. OR Adults who are at risk of requiring acute psychiatric inpatient care, residential treatment, or an outpatient crisis intervention.

Criteria 2: Designated as Underserved or Unserved (CCR §3200.300 and 3200.310)

Individuals enrolled in a Full Service Partnership program must meet the MHSA definition of an individual who is underserved or unserved by mental health services, as described in the California Code of Regulations.

Underserved	Unserved
"Underserved" means clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client's recovery, wellness and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out of home placement or other serious consequences; members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas, Native American rancherias and/ or reservations who are not receiving sufficient services.	**"Unserved"** means those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved.

Criteria 3: MHSA Criteria for Full Service Partnership Category (CCR § 3620.05)

Individuals enrolled in a Full Service Partnership programs must meet the MHSA eligibility criteria for enrollment.

- All children and youth identified at risk and seriously emotionally disturbed (SED) as a result of a mental health diagnosis, are eligible for enrollment in a Full Service Partnership Program.
- All others, (including, Transitional Age Youth, Adults, and Older Adults) must meet the following additional criteria:

Transitional Age Youth (Ages 16-25)	Adults (Ages 26-59)	Older Adults (Ages 60 and Older)
TAYS are unserved or underserved and one of the following: • Homeless or at risk of being homeless. • Aging out of the child and youth mental health system. • Aging out of the child welfare systems • Aging out of the juvenile justice system. • Involved in the criminal justice system. • At risk of involuntary hospitalization or institutionalization. Have experienced a first episode of serious mental illness.	(1) Adults are unserved and one of the following: • Homeless or at risk of becoming homeless. • Involved in the criminal justice system. • Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment. OR (2) Adults are underserved and at risk of one of the following: • Homelessness. • Involvement in the criminal justice system. • Institutionalization.	Older Adults are unserved experiencing, or underserved and at risk of, one of the following: • Homelessness. • Institutionalization. • Nursing home or out-of-home care. • Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment. • Involvement in the criminal justice system.

Criteria 4: San Joaquin County Priority Service Needs

San Joaquin County has developed further clarification on the criteria for enrollment in a Full Service Partnership program, based on the priority service needs expressed during the MHSA Community Program Planning Process.

- For children and youth ages 3-17, Full Service Partnership Program enrollment will prioritize recipients of Child Welfare Services (e.g. foster care services); Juvenile Justice Services (e.g. juvenile detention or probation); or any Crisis Mental Health Services.
- Transitional Age Youth, Adults, and Older Adults eligible for enrollment in a Full Service Partnership Program will have a high acuity of impairment *and* have one or more of the following specific conditions:

Baseline Priority: Acuity of Impairment	**Local Priority 1: Homeless**	**Local Priority 2: Other At-Risk Conditions**
Clinical Indication of Impairment • As indicated by a score within the highest range of needs on a level of care assessment tool*. *BHS has reviewed and piloted a level of care assessment tool. Use of the *Child and Adult Needs and Strengths Assessment (*CANSA) tool is currently being implemented throughout BHS's clinical program areas.	Homeless; or, • Living on the street, in a vehicle, shelter, a motel, or a place not typical of human habitation. Imminent Risk of Homelessness; or • Having received an eviction notice, living in temporary housing that has time limits, discharged from health facility or jail without a place to live. * In consultation with stakeholders BHS is making the provision of FSP Services a priority for all individuals with serious mental illnesses who are homeless or at imminent risk of homelessness. This prioritization also aligns with the priorities outlined by members of the Board of Supervisors interviewed for this Plan.	Involved with the Criminal Justice System; • Recent arrest and booking • Recent release from jail • Risk of arrest for nuisance of disturbing behaviors • Risk of incarceration • SJC collaborative court system or probation supervision, including Community Corrections Partnership Frequent Users of Emergency or Crisis Services; or • Two or more mental health related Hospital Emergency Department episodes in past 6 months • Two or more Crisis or Crisis Stabilization Unit episodes within the past 6 months At risk of Institutionalization. • Exiting an IMD • Two or more psychiatric hospitalizations within the past 6 months • Any psychiatric hospitalization of 14 or more days in duration. • LPS Conservatorship

Full Service Partnership Program Implementation in San Joaquin County

The foundation of San Joaquin County's FSP Program is the provision of a full spectrum of community supports and services (e.g. housing, employment, education, mobile crisis response, peer support, and substance abuse treatment services) to sustain and stabilize individual consumers within their recovery process. FSP Programs have a high staff to consumer ratio, and a team approach that is predicated upon the partnership between the consumer, the mental health clinical team, and family or peer partners in recovery.

BHS will operate five FSP Programs and three intensive FSP programs for very high-risk individuals that are (1) extremely reluctant to engage in mental health services, (2) at imminent risk of institutionalization, or (3) have a history of repeated contact with law enforcement for serious offenses.

Standard FSP Programs

- Children and Youth FSP
- Transitional Age Youth FSP
- Adult FSP
- Older Adult FSP
- Community Corrections FSP

Enhanced FSP Programs

- InSPIRE:
  for individuals with serious mental illnesses who are extremely reluctant to engage in services
- Intensive Adult:
  for individuals with serious mental illnesses who are at imminent risk of institutionalization
- Intensive Justice Response:
  for individuals with serious mental illnesses who commit serious offenses
- *High Risk Transition Team*
  For individuals with serious mental illness transitioning from institutionalization to other services

BHS also operates several programs that are designed for the exclusive use of FSP clients including: *FSP Housing Empowerment Services* (available for eligible FSP Clients ages 18 and over) and long-term *Adult Residential Treatment Services* for FSP clients and FSP eligible clients that require enhanced engagement or specialty services to avoid institutionalization and stabilize in treatment services.

Accessibility and Cultural Competence

Equal Access:

FSP program services are available to all individuals that meet the clinical eligibility criteria for specialty mental health care and full service partnership programming without regard to the person's race, color, national origin, socio-economic status, disability, age, gender identification, sexual orientation, or religion. All program partners are required to take reasonable steps to ensure that organizational behaviors, practices, attitudes, and policies respect and respond to the cultural diversity of the communities and clients served.

Linguistic Competence:

FSP program services are delivered in a manner which factors in the language needs, health literacy, culture, and diversity of the population that is served. Information and materials are available in multiple languages and trained mental health translators are assigned as needed to ensure comprehension and understanding by the clinical team of the client's recovery goals and agreement or adherence to the treatment plan. All program partners are required to provide meaningful access to their programs by persons with limited English proficiency.

FSP programs also offer a range of culturally competent services and engagement to community-based resources designed for:

- African American consumers
- Asian / Pacific Islander consumers, including services in:
    - *Cambodian / Khmer*
    - *Hmong, Laotian, Mien*
    - *Vietnamese*
- Latino/Hispanic consumers, including services in
    - *Spanish*
- Lesbian, gay, bisexual and transgender consumers
- Middle Eastern consumers
- Native American consumers

BHS is continually striving to improve cultural competence and access to diverse communities. All partners are expected to provide meaningful linguistic access to program services and to address cultural and linguistic competency within their organization.

Full Service Partnership Program Services

FSP Engagement:

- *Enthusiastic Engagement:* Individuals with serious mental illnesses that do not respond to engagement services as usual may be referred to the InSPIRE FSP team. Enthusiastic engagement refers to a program strategy that supports daily attempts at contact and finding creative pathways to treatment services for hesitant or reluctant clients. This is an Enhanced FSP program with a limited case load. Following successful engagement clients are transitioned to an appropriate FSP program for ongoing treatment and supports.

- *Transition to Treatment:* Individuals that are treated within the BHS crisis continuum (Crisis Services, Crisis Stabilization Unit, or Psychiatric Health Facility) are discharged with a transition to treatment plan that includes a scheduled follow-up appointment and linkage to routine services. Peer navigators are also a part of the transition to treatment process following a crisis episode and may be a component of the discharge plan.

FSP Assessment and Referral Process:

- *Assessment:* Prior to receiving treatment services for a serious mental illness, all individuals must undergo a complete psychosocial assessment to evaluate their mental health and social wellbeing. The assessment examines clinical needs, perception of self, and ability to function in the community. The assessment process may also include an assessment of substance use disorders. The assessment is typically completed by a Mental Health Clinician through a scheduled appointment or as a component of a crisis evaluation – though in some (limited) instances it may be completed by a psychiatrist or psychologist.

- *Referral to Care:* Based on the assessment, the Clinician will develop a preliminary treatment plan and make a referral to the appropriate level of care. Depending on the findings of the assessment this may be a referral to a primary care physician or health plan to address a mild-moderate mental health concern; a referral to an outpatient clinic to enter into routine treatment services; or a referral to either standard or enhanced FSP services, per the MHSA eligibility criteria reviewed above *and* the purpose and capacity of the FSP program to address individual treatment needs.

FSP Enrollment into a Treatment Team

- *FSP Treatment and Support Team:* Individuals enrolled in an FSP program will have a treatment team that includes a clinician, nursing or medical staff, case manager, and frequently a peer or parent partner with lived experience in recovery is part of the team. FSP treatment teams

provide targeted clinical interventions and case management and work with community based partners to offer a full range of wraparound services and supports.

- *Orientation to FSP Services:* FSP program staff will evaluate the needs and orient the eligible consumer to the program philosophy and process; providing enough information so that the consumer can make an informed choice regarding enrollment. This process is used to explore the natural supports individuals have to build into recovery efforts, including family and community supports and to further understand treatment needs. Clinicians will conduct comprehensive clinical assessment to make recommendations for treatment and service interventions which are outlined in the Client Treatment Plan.

- *Partnership Assessment Form:* The Partnership Assessment Form (PAF) is completed once, when a partnership is established within a FSP program. The PAF is a comprehensive intake that establishes history and baseline data in the following areas: residential, education, employment, sources of financial support, legal issues, emergency interventions, health status, substance abuse, and other special age and dependency related concerns.

- *Enhanced FSP Treatment Team:* All services described above, and additionally; Individuals enrolled in one of the Enhanced FSP Programs will be engaged by a larger treatment team that may additionally include an alcohol and drug counselor; and a housing, rehabilitation, or vocational specialist as part of the team. There is a low ratio of clients to treatment team staff; ideally 10:1, but not less than 15:1. The treatment team also has 24-hour responsibility responding to a psychiatric crisis and will respond at the time of any hospital admission.

FSP Treatment and Recovery Plan

- *(TAY, Adult, and Older Adult) Client Treatment Plan*: Plans describe the treatment modalities and services recommended to support recovery. Planning may occur in one or more sessions and will be completed within 60 days of enrollment. Plans include a *Strength Assessment* that highlights the interests, activities and natural supports available to the consumer and the core areas of life, or domains, (e.g. housing or personal relationships) they wish to focus on through treatment. Clients will be evaluated by a psychiatrist to review and discuss medications as a component of the treatment plans. Client Treatment Plans will be updated every six months.

- *(Children and Youth) Service Support Plan*: For youth in treatment in a FSP, service support plans describe the treatment modalities and services recommended to support recovery. Planning may occur in one or more sessions. Plans include a *Strength Assessment* that highlights the interests, activities and natural supports available to the consumer and the core areas of life, or domains, (e.g. housing or personal relationships) they wish to focus on through treatment. Plans will be updated as needed or every six months. The plan is developed through Child Family Team meetings conducted every 30 days.

- *Wellness Recovery Action Plan (WRAP):* Adult Consumers will work with peer partners to develop their own WRAP plans with strategies to decrease and prevent intrusive or troubling

thoughts and to increase positive activities and quality of life. WRAP plans are consumer-directed and empowerment focused.

Clinical and Service Interventions:

- *Psychiatric Assessment and Medication Management: FSP* Consumers will meet with a prescribing practitioner to determine appropriate medications and will be followed by a nurse or psychiatric technician to ensure that the prescribed medications are having the desired effects. Follow-up visits with the psychiatrist or prescribing practitioner will be scheduled as needed to refine or adjust prescriptions. Additionally, case management services may include daily or weekly reminders to take medications as prescribed.

- *Clinical Team Case Management:* FSP Consumers are enrolled into a clinical team that provides intensive home or community-based case management. The frequency of contact is directed by consumer needs and level of care. With most FSP programs clients are seen 1-3 times a week. Within enhanced FSP programs clients have 3-6 contacts per week. Case Management services include:
    - Treatment planning and monitoring of treatment progress
    - Individualized services and supports
    - Group services and supports
    - Referrals and linkages to health care services, public benefit programs, housing, legal assistance, etc.

- *Individual interventions:* FSP consumers receive individualized interventions from a clinician. BHS clinicians are trained in several modalities. Consumers work with clinicians that have training in the modality that best meets their treatment needs. Individual therapeutic approaches to support consumers may include:
    - Cognitive Behavioral Therapies, including for psychosis
    - Trauma Focused Cognitive Behavioral Therapy
    - Parent Child Interactive Therapy

- *Cognitive Behavioral and Skill-Building Groups:* FSP consumers will additionally participate in group skill building and treatment activities. Group activities are intended to further refine, reflect, and practice the behaviors and thinking-patterns identified within the WRAP and treatment plans. Consumers with co-occurring disorders will also be screened for substance use disorder treatment services, including residential or outpatient treatment services. A range of evidence-based treatment and support groups may be offered, including, but not limited to:

    - Aggression Replacement Training
    - Anger Management for Individuals with Co-occurring Disorders
    - Chronic Disease Self-Management Skills
    - Dialectical Behavior Therapy

- Seeking Safety (a trauma-informed, cognitive behavioral treatment)
- Matrix (a cognitive behavioral substance use disorders)
- Cognitive Behavioral Interventions for substance use disorders
- Various peer and consumer-driven support groups

- *Additional Clinical Supports:*
  - Community Behavioral Intervention Services are available to adult and older adult FSP clients who are having a hard time managing behaviors and impulses and have experienced a severe loss of functioning. The services are based on the principles of *Applied Behavioral Analysis* and intended to address specific behaviors to support long-lasting functional change.
  - Intensive Home Based Services and Care Coordination are available for children, youth, and their families for any children or youth who meet Specialty Mental Health Services, and who would benefit from those services.
  - Substance Use Disorder Treatment Services are available through the Substance Use Services Division and include a range of outpatient, intensive outpatient, and residential treatment programs. BHS also contracts with qualified community partners to provide medication assisted treatment for individuals with co-occurring disorders.

- *Additional Community Supports:* A broad range of community, housing, and employment support services are also available to consumers enrolled in an FSP program. Programs funded through MHSA are described in Systems Development Projects, and include:
  - Wellness Centers
  - Peer Navigation
  - Mobile Crisis Support Team
  - Housing Empowerment Programming
  - Employment Recovery Services

- *Enhanced FSP Services:* Individuals enrolled within one of the enhanced FSP programs will receive all housing, rehabilitation, substance use treatment and additional clinical support services through their FSP treatment team.

- *FSP Housing Services:* Individuals with serious mental illnesses need a stable place to live in order to manage their recovery, participate effectively in treatment, and address their own health and wellness. FSP program participants may be eligible for one of several housing programs, with services ranging from assistance finding housing to placements in more long term assisted living facilities. Housing related services and supports are based upon individual assessment of needs and strengths and the treatment plan and vary significantly.

- "Whatever It Takes" funding set aside to help consumers achieve their recovery goals. These funds assist in paying for resources when typical services are unavailable. (MHSA CCR Title 9 Section 3260 (a) (1) (B). FSP Programs are guided by agency "Client Expense Policy".

Monitoring Treatment Progress

- *Monitoring and Adapting Services and Supports:* A level of care assessment will be re-administered every six months and will be used to inform and update the intervention recommendations described in a *Client Treatment Plan*.
    - The *Child and Adult Needs and Strengths Assessment* (CANSA) is used to measure and track client progress. The CANSA is made of domains that focus on various areas in an individual's life, and each domain is made up of a group of specific items. There are domains that address how the individual functions in everyday life, on specific emotional or behavioral concerns, on risk behaviors, on strengths and on skills needed to grow and develop, and on general family concerns. The provider gives a number rating to each of these items. These ratings help the provider, client and family understand where intensive or immediate action is most needed, and also where an individual has assets that could be a major part of the treatment or service plan.

- *Quarterly Assessment Form:* The Quarterly Assessment Form is completed every three months following the enrollment. This is an abbreviated version of the PAF intake form and documents for client status of key performance measures in the areas of education, sources of financial support, health status, substance use, and legal issues (incarceration, dependency, and legal guardianship), etc.

- *Key Event Tracking Form:* A key event tracking (KET) form is completed every time there is a change in status in one of the following key areas: housing status/change; hospitalization; incarceration, education; employment; legal status (dependency, guardianship, etc.); or if there has been an emergency crisis response.

Transition to Community or Specialty Mental Health Services

- *Transition Planning:* Transition planning is intended to help consumers "step-down" from the highly intensive services of the full service partnership program into specialty and/or community based mental health services. Indicators that a consumer is ready to step-down include, increase stability in housing; increase functionality as indicated by attainment of treatment goals; completion of therapeutic interventions and readiness as determined by the FSP clinical team; and clients ability to move successfully to a lower level of care.

- *Engagement into Community or Specialty Mental Health Services*: All FSP consumers will have a *FSP Discharge Process* that includes a specific plan for follow up, linkage to a lower level of care, community resources to support progress obtained and stability in living environment. Adult consumers will be encouraged to develop (or update) their own wellness recovery action plan.

- *Post FSP Services*: FSP consumers stepping down from an FSP program will be linked with an FSP Engagement worker. The FSP Engagement program conducts community-based engagement services to help individuals and their families overcome stigma or other concerns about seeking mental health treatment services. Engagement workers will ensure that individuals who have stabilized in treatment services will remain stable by providing regular follow-up services to ensure satisfaction and engagement with new treatment services and continued stability in the community for a period of up to six months following discharge from an FSP.

Community Services and Supports Funded Programs

Full Service Partnership

1. Children and Youth FSP
2. Transitional Age Youth (TAY) FSP
3. Adult FSP
4. Older Adult FSP
5. Community Corrections FSP
6. InSPIRE FSP
7. Intensive Adult FSP
8. Intensive Justice Response FSP
9. High-Risk Transition Team FSP
10. Housing Empowerment Services
11. Adult Residential Treatment Services

Outreach & Engagement

12. Mental Health Outreach & Engagement
13. Mobile Crisis Support Team
14. Peer Navigation

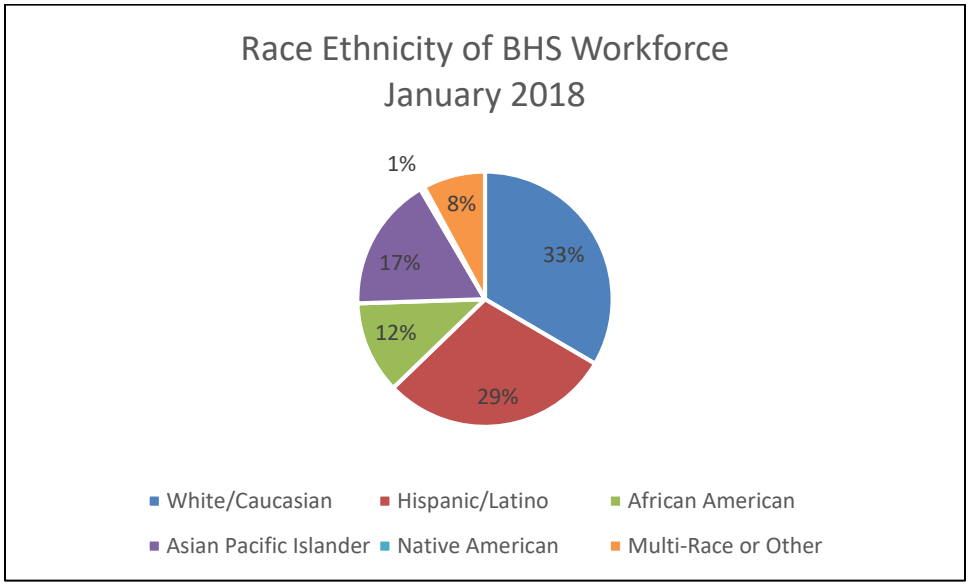
General System Development

15. Wellness Center
16. Project Based Housing
17. Employment Recovery Services
18. Community Behavioral Intervention Services
19. Housing Coordination Services
20. Crisis Services Expansion
21. System Development Expansion

Capacity to Implement CSS Programs

Over 1,000 mental health services staff and partners work throughout the county to deliver mental health services to approximately 16,000 individuals with serious mental illness (a 16:1 ratio of clients to partners and staff). BHS employs the largest proportion of the workforce (N=782) or 77% of the workforce. CBO partners and other network providers account for the remaining portion of the workforce.

The mental health workforce is comprised of licensed and unlicensed personnel (31% and 39%, respectively), as well as managerial and support staff. Staffing shortages are challenging for many positions, with licensed positions being the hardest to fill; recruitments are ongoing and continuous for licensed mental health clinicians, psychiatric technicians, and psychiatrists.



BHS works hard to recruit and retain a diverse workforce. Compared to the general population the BHS workforce is relatively diverse, and somewhat reflective of the residents of San Joaquin County. Data shows that Hispanic/Latino individuals are under-represented in the workforce, comprising 29% of the workforce, compared to 42% of the county population and 46% of Medi-Cal Beneficiaries.

Further details about language capacity and cultural competency at BHS are in the Cultural Competency Plan, located in the Appendix. The Cultural Competency Plan provides more insight on the strengths and limitations of the workforce to serve a diverse population and describes the ongoing activities and strategies to strengthen the workforce and meet community needs.

CSS Full Service Partnership Program Work Plans

Funding is allocated towards eight FSP programs that are implemented by seventeen different clinical teams comprised of psychiatrists, clinicians, case managers, peer partners, nurses, psychiatric technicians and others. Annually, over 1,700 individuals receive services within San Joaquin's FSP programs. FSP program participants may also participate in one or more specialty programs for FSP clients that need additional services and supports beyond those usually provided by a FSP team.

	Unique Count of Clients Served in FY 2017/18
Full Service Partnership Programs	
1. Children and Youth FSP (2 Teams)	606
2. Transitional Age Youth (TAY) FSP (1 Team)	92
3. Adult FSP (7 Teams)	1,713
4. Older Adult FSP (1 Team)	117
5. Community Corrections FSP (1 Team)	303
6. InSPIRE FSP (1 Team)	30
7. Intensive Adult FSP (2 Teams, launching in 2019)	0
8. Intensive Justice Response FSP (2 Teams, launching in 2019)	0
9. High Risk Transition Team FSP (1 Team; launching in 2019)	0
TOTAL CLIENTS ENROLLED IN FSP PROGRAMS	**2,861**

CSS Project 1: Children and Youth FSP

Project Description

The Children and Youth Services FSP programs provide intensive and comprehensive mental health services to children and youth who have not yet received services necessary to address impairments; reduce risk of suicide, violence, or self-harm; or to stabilize children and youth within their own environments (see FSP Enrollment Criteria 1, page 34). Full Service Partnership program interventions are targeted for children and youth who are: (1) juvenile justice involved, or (2) engaged with the Child Welfare System or (3) diagnosed with a serious mental illness or severe emotional disturbance that necessitates service interventions beyond the scope of traditional specialty mental health care.

Target Populations:

1. **Dependency Population:** FSP programs serve children and youth that are in the dependency system. All children and youth that meet California's Pathways to Wellbeing and Intensive Care Coordination requirements are eligible for FSP services.
2. **Children and Youth:** FSP programs serve children and youth that have a severe emotional disorder and /or a diagnosed serious mental illness that require a full spectrum of services and supports to meet recovery goals.

Project Components

There are four FSP teams working with children and youth.

Intensive FSPs for Children and youth in the Dependency System

1. Dependency FSP Team

The vast majority of children and youth served by this FSP are simultaneously involved with the juvenile justice system or the child welfare system, or both. The clinical team has special training in working with the dependency system and works under partnership agreements with local agencies. The purpose of the Dependency FSP team is to provide a very intensive level of engagement and stabilization services with a goal of stepping clients down into one of the Standard FSP Treatment Teams as recovery goals are met.

2. MHSA Pathways FSP Team

This FSP serves children and youth with the highest and most acute treatment needs. Youth will receive community-based Intensive Care Coordination (ICC) in compliance with State mandates, and Intensive Home Based Services (IHBS) per State Medi-Cal regulations. ICC will include the practice of teaming with the child/youth, family, child welfare social worker, probation officer, mental health worker, and other supports through the use of CANSA informed Child and Family Teams (CFT). Contracted staff are CANSA certified and skilled in the use of methods of team facilitation in order to ensure effective engagement and inclusion of the child/youth and family.

Standard FSPs

3. *BHS Child and Youth (CYS) FSP Team*

4. *Community Contracted CYS FSP Team*

In addition to providing a full spectrum of clinical treatment services, CYS FSP program activities are designed to support the social, emotional, and basic living needs of *children and their families* to ensure ongoing participation in treatment services and stabilization in the recovery process. CYS FSP services work with children ages 0-18, and their families.

Clients Served within the Children and Youth FSP Program

Client Demographics:

Children and Youth FSP Program 2017-2018 N=606		
	Number	**Percent**
Total by Age Group Served		
▪ Children and Youth	579	96%
▪ Transitional Age Youth	27	4%
Gender Identity		
▪ Female	338	56%
▪ Male	268	44%
Race/Ethnicity		
▪ African American	156	26%
▪ Asian / Pacific Islander	22	4%
▪ Hispanic/Latino	183	30%
▪ Native American	4	1%
▪ White/Caucasian	197	33%
▪ Other / Not-Identified	44	7%
Linguistic Group		
▪ English	545	90%
▪ Spanish	61	10%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	0	0%

Cost per Client:

Number Served	**Total Expenditures**
606	$4,834,269
Average Annual Cost	**Average Monthly Cost**
$7,977	$665

Client Projections:

BHS projects that the number and composition of CYS FSP clients served in 2017-2018 will remain relatively consistent for FY 2019-2020. BHS is implementing an Intensive FSP to meet California's Pathways to Wellbeing and Intensive Care Coordination requirement.

Insert FSP – CYS Budget

CSS: FSP-Children & Youth FSP

Cost Center(s): 6320,6325,6321, New TBD
RU(s): 9095FS, 9095AP, 9095EC, 9095MM

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	1.750		$221,317.00	$195,411.00	$123,063.00
Deputy Director BHS- Clinical	0.350			$52,677.00	$28,050.00
Mental Health Clinician I	6.000			$396,621.00	$187,373.00
Mental Health Clinician II	3.600		$262,259.00	$262,702.00	$284,678.00
Mental Health Clinician III	4.800			$392,106.00	$272,176.00
Mental Health Outreach Worker	2.500			$87,162.00	$34,697.00
Mental Health Specialist II	10.250			$467,599.00	$346,617.00
Office Assistant	3.450			$121,100.00	$113,250.00
Office Assistant Specialist	0.500			$22,890.00	$18,893.00
Office Supervisor	1.000			$48,318.00	$34,197.00
Registered Nurse	0.500			$61,087.00	$48,010.00
				$0.00	$0.00
				$2,107,673.00	**$1,491,004.00**
Total	34.70			**$3,598,677.00**	
Overtime				$500.00	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET**
OPERATING COSTS	$332,342.72	$52,823.87	$111,796.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$1,081.29		$11,700.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$732,132.24	$370,760.69	$2,464,695.00
ADMINISTRATIVE / INDIRECT	$251,603.79		
PERSONNEL COSTS	$1,643,817.71	$1,076,803.48	$3,599,177.00
TOTAL GROSS EXPENDITURES	**$2,960,977.75**	**$1,500,388.04**	**$6,187,368.00**
Offsetting Revenue			
Medi-Cal	$731,552.00		$1,023,683.00
Realignment	$0.00		$977,085.00
Other	$316,811.00		$960.00
Total	**$1,048,363.00**	**$0.00**	**$2,001,728.00**
TOTAL NET EXPENDITURES	**$1,912,614.75**	**$1,500,388.04**	**$4,185,640.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Small furniture and Equipment $$4,300 Computers $7,400

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Therapeutic Foster Care- Short Term Residential Theraputic Programs - Victor Community Support Services

CSS Project 2: Transitional Age Youth (TAY) FSP

Project Description

The TAY FSP provides intensive and comprehensive mental health services to unserved and underserved transitional age youth 18-25 with a diagnosed mental illness who are having difficulty stabilizing in and managing their own treatment and recovery.

Services are designed to meet the needs of adolescents and young adults, with an emphasis on recovery and wellness through an array of community services to assist TAY consumers in developing the skills and protective factors to support self-sufficiency. TAY FSP services include age-specific groups and support services and features a clinical team experienced in helping adolescents and young adults learn how to manage their recovery and transition to adulthood.

Target Population 1: Exiting or Former Foster Care Youth

- *(SED/SMI) Adolescents 18-21,* who are exiting foster care system or were at one time in the foster care system. In addition to the full spectrum of mental health and support services provided within an FSP, services are designed to teach chronic illness management skills and to find and engage caring adults and/or peers to support treatment and recovery process.

Target Population 2: Transitional Age Youth

- *Young adults 18-25,* with serious mental illness and/or co-occurring substance use disorders. Services include a high-focus on doing "whatever-it takes" to stabilize and engage individuals into treatment services, including providing a range of readiness for recovery services such as extended engagement, housing supports, substance use disorder treatment services, and benefit counseling prior to the formal "enrollment" into mental health treatment services.

Project Components

There is one FSP team working with Transitional Age Youth.

Clients Served within the Transitional Age Youth (TAY) FSP Program

Client Demographics:

Transitional Age Youth FSP Program 2017-2018 N=92		
	Number	**Percent**
Total by Age Group Served		
▪ Children and Youth	81	88%
▪ Transitional Age Youth	11	12%
Gender Identity		
▪ Female	39	42%
▪ Male	53	58%
Race/Ethnicity		
▪ African American	23	25%
▪ Asian / Pacific Islander	5	5%
▪ Hispanic/Latino	13	14%
▪ Native American	2	2%
▪ White/Caucasian	42	46%
▪ Other / Not-Identified	7	8%
Linguistic Group		
▪ English	86	93%
▪ Spanish	4	4%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	2	2%

Cost per Client:

Number Served	**Total Expenditures**
92	$855,879
Average Annual Cost	**Average Monthly Cost**
$9,303	$775

Client Projections:

BHS projects that the number and composition of TAY FSP clients served in 2017-2018 will remain relatively consistent for FY 2019-2020. No significant program expansions or contractions are predicted.

CSS: FSP-Transition Age Youth (TAY) FSP

Cost Center(s): 6375
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	2.50			$257,446	$150,679
Mental Health Clinician I	0.25			$17,282	$8,599
Mental Health Clinician III	0.29			$22,825	$15,228
Mental Health Outreach Worker	2.00			$75,611	$63,673
Mental Health Specialist II	2.00			$84,833	$69,221
Psychiatrist	0.11			$28,583	$13,349
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$486,580	**$320,749**
Total	7.1462			**$807,329**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$110,029.27	$17,526.60	$44,700.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		$2,200.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$1,134.09		$1,650.00
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$46,645.69		
PERSONNEL COSTS	$391,136.78	$197,014.12	$807,329.38
TOTAL GROSS EXPENDITURES	**$548,945.83**	**$214,540.72**	**$855,879.38**
Offsetting Revenue			
Medi-Cal	$231,618.00		$298,109.00
Realignment	$0.00		$1,360.00
Other	$1,657.00		
Total	**$233,275.00**	**$0.00**	**$299,469.00**
TOTAL NET EXPENDITURES	**$315,670.83**	**$214,540.72**	**$556,410**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Small furniture & equipment $2,000 Computer supplies $200

Brief description of items included in Consultant/Contract Costs:

Contract Psychiatry $1,650

Brief description of items included in Contracted Service Provider:

CSS Project 3: Adult FSP

Project Description

Adult FSP services are available throughout the county for any adult with serious mental illness who meets the criteria for FSP enrollment, with priority enrollment given to individuals who are currently homeless, involved with the criminal justice system, frequent users of crisis or emergency services, or are at-risk of placement in an institution.

Target Population:

- *Adults 26-59,* with serious and persistent mental illnesses that have not otherwise stabilized in their recovery through specialty mental health services, and who are unserved or underserved, and experiencing at least one of the following (*see eligibility criteria p. 34-36*):
    - Involvement with the criminal justice system
    - Homeless or at imminent risk of homelessness
    - Frequent emergency room or crisis contacts to treat mental illness
    - At risk of institutionalization

Project Components

There are a variety of FSP teams working with Adults who have serious mental illnesses.

1. **Intensive FSP**
   BHS has three intensive FSP teams to serve adults with serious mental illnesses who require additional wrap-around services and supports in order to engage and stabilize clients into standard FSP programs. The Intensive FSP teams are described as CSS Projects #6 and #7 in order to better define and account for the specialized services provided by these teams.

2. **Standard FSP**
   Black Awareness and Community Outreach Program (BACOP) FSP Team
   Community Adult Treatment Services (CATS) FSP Teams
    - *Intensive Care Engagement*
    - *Adult Recovery Treatment Services*

   La Familia FSP Team
   Lodi FSP Team
   South East Asian Recovery Services (SEARS) FSP Team
   Tracy FSP Team

Adult FSP programs provide a full spectrum of treatment services and supports to address the social, emotional, and basic living needs of *adults with serious mental illness* to ensure ongoing participation in treatment services and stabilization in the recovery process. Adult FSP services work with individuals ages 18 and over. Enrollment into teams is based on client needs and preferences.

Clients Served within the Adult FSP Program

Client Demographics:

Adult FSP Program 2017-2018 N=1,713		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	21	1%
▪ Adults	1175	69%
▪ Older Adults	47	3%
Gender Identity		
▪ Female	941	55%
▪ Male	772	45%
Race/Ethnicity		
▪ African American	395	23%
▪ Asian / Pacific Islander	205	12%
▪ Hispanic/Latino	407	24%
▪ Native American	130	8%
▪ White/Caucasian	557	33%
▪ Other / Not-Identified	19	1%
Linguistic Group		
▪ English	1326	77%
▪ Spanish	247	14%
▪ Other, Asian	92	5%
▪ Arabic or Farsi	4	0%
▪ Other non-English	44	3%

Cost per Client:

Number Served	**Total Expenditures**
1,713	$10,254,142
Average Annual Cost	**Average Monthly Cost**
$5,986	$499

Client Projections:

BHS projects that the number and composition of Adult FSP clients served in 2017-2018 will remain relatively consistent for FY 2019-2020. No significant program expansions or contractions are predicted.

CSS: FSP-Adult FSP

Cost Center(s): 6311,6312,6313, 6330,6340,6350
RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	2.26			$259,552.68	$153,326.00
Chief Psychiatric Technician	1.00			$64,438.40	$43,038.00
Deputy Director	0.26			$39,657.39	$21,117.00
Mental Health Clinician I	14.03			$956,184.81	$677,295.00
Mental Health Clinician II	2.74			$219,678.85	$156,990.00
Mental Health Clinician III	2.58			$233,284.76	$155,075.00
Mental Health Interpreter II	2.80			$118,639.04	$111,806.00
Mental Health Outreach Worker	8.78			$332,184.64	$229,351.00
Mental Health Specialist II	14.00			$743,908.18	$526,879.00
Mental Health Specialist III	1.31			$76,839.50	$53,939.00
Nurse Practitioner II	0.50			$53,789.00	$25,214.00
Nursing Departement Manager	0.22			$38,047.62	$19,239.00
Office Assistant	2.80			$115,517.09	$64,063.00
Office Assistant Specialist	0.31			$14,192.05	$14,184.00
Office Supervisor	1.25			$61,563.69	$46,315.00
Office Worker II	0.75			$31,153.00	$2,399.00
Psychiatric Technician	3.87			$182,880.22	$75,360.00
Psychiatrist	4.02			$1,136,016.17	$244,838.00
Sr. Nurse Practitioner	0.37			$33,410.95	$21,554.00
Sr. Office Assistant	8.77			$370,979.70	$263,304.00
Sr Psychiatric Technician	0.82			$48,643.40	$28,261.00
Staff Nurse III	1.31			$138,245.25	$83,901.00
Staff Nurse IV	2.56			$315,520.64	$197,346.00
				$0.00	$0.00
Total	77.31			**$5,584,327.03**	**$3,214,794.00**
					$8,799,121.03
Overtime				$8,339.00	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$5,253,818.16	$946,173.95	$999,920.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$7,353.52		$74,318.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$655,497.56		$372,444.00
ADMINISTRATIVE / INDIRECT	$878,984.27		
PERSONNEL COSTS	$3,548,598.05	$4,211,731.54	$8,807,460.03
TOTAL GROSS EXPENDITURES	**$10,344,251.56**	**$5,157,905.49**	**$10,254,142.03**
Offsetting Revenue			
Medi-Cal	$4,242,261.00		$5,275,843.00
Realignment	$0.00		$281.00
Other	$54,617.00		$26,700.00
Total	**$4,296,878.00**	**$0.00**	**$5,302,824.00**
TOTAL NET EXPENDITURES	**$6,047,373.56**	**$5,157,905.49**	**$4,951,318.03**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

One 4 door sedan for client transport $35,000 Small furniture & equipment $12,797 Computer & software $26,521

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Contract Psychiatry $372,444

CSS Project 4: Older Adult FSP

Project Description

The Gaining Older Adult Life Skills (GOALS) FSP provides individualized and focused treatment to older adults 60 and over with serious mental illness and/or co-occurring substance use disorders. The Older Adult FSP focuses on older adults with serious and persistent mental illness who require more extensive services and supports to successfully engage in treatment services, including linkages to other needed services, such as primary health care, supportive housing, transportation assistance, nutrition care, and services to prevent isolation and depression. The Older Adult program works collaboratively with consumers, family members, housing providers, and other service providers to ensure that consumers can live safely and independently within their community.

Target Population:

- *Older Adults 60 and over,* with serious mental illness and one or more of the following:
  - Homeless or at imminent risk of homelessness
  - Recent arrest, incarceration, or risk of incarceration
  - At risk of being placed in or transitioning from a hospital or institution
  - Imminent risk of placement in a skilled nursing facility (SNF) or nursing home or transitioning from a SNF or nursing home
  - At-risk for suicidality, self-harm, or self-neglect
  - At-risk of elder abuse, neglect, or isolation

Project Components

- There is one FSP team working with Older Adults who have serious mental illnesses.

Clients Served within the Older Adult FSP Program

Client Demographics:

Older Adult FSP Program 2017-2018 N=117		
	Number	**Percent**
Total by Age Group Served		
▪ Older Adults	117	100%
Gender Identity		
▪ Female	68	58%
▪ Male	49	42%
Race/Ethnicity		
▪ African American	28	24%
▪ Asian / Pacific Islander	23	20%
▪ Hispanic/Latino	22	19%
▪ Native American	3	3%
▪ White/Caucasian	35	30%
▪ Other / Not-Identified	6	5%
Linguistic Group		
▪ English	75	64%
▪ Spanish	16	14%
▪ Other, Asian	20	17%
▪ Arabic or Farsi	0	0%
▪ Other non-English	6	5%

Cost per Client:

Number Served	**Total Expenditures**
117	$1,328,181
Average Annual Cost	**Average Monthly Cost**
$11,352	$946

Client Projections:

BHS projects that the number and composition of Older Adult FSP clients served in 2017-2018 will remain relatively consistent for FY 2019-2020. No significant program expansions or contractions are predicted.

CSS: FSP-Older Adult FSP

Cost Center(s): 6370
RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	0.50			$65,653.00	$35,556.00
Deputy Director BHS- Clinical	0.15			$22,575.00	$12,021.00
Mental Health Clinician I	1.50			$106,078.00	$68,673.00
Mental Health Clinician II	0.50			$33,010.00	$23,158.00
Mental Health Clinician III	0.50			$47,850.00	$33,703.00
Mental Health Outreach Worker	1.50			$54,646.00	$4,208.00
Mental Health Outreach Worker Trainee	0.38			$12,251.00	$944.00
Mental Health Specialist II	1.00			$59,275.00	$17,926.00
Office Assistant Specialist	0.75			$34,336.00	$24,602.00
Psychiatric Technician	0.25			$12,308.00	$9,643.00
Psychiatrist	0.83			$222,041.00	$99,091.00
Rehabilitation Specialist I	0.25			$15,044.00	$11,418.00
Staff Nurse IV- Cinical Ambulatory	0.50			$62,541.00	$46,449.00
				$709,261.00	**$370,957.00**
Total	8.60			**$1,080,218.00**	
Overtime					$100.00

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)	
OPERATING COSTS	$343,827.48	$72,646.67	$102,863.00	
NON-RECURRING COSTS (Equipment, Technology, etc)	$16,527.52		$5,000.00	
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		$0.00	
CONTRACTED SERVICE PROVIDER	$172,565.80	$99,852.13	$140,000.00	
ADMINISTRATIVE / INDIRECT	$135,728.55	$1,952.57		
PERSONNEL COSTS	$928,660.58	$673,305.67	$1,080,318.00	<<<If Personnel costs are separated out; otherwise include ONLY FOR FY17-18 & 18-19.
TOTAL GROSS EXPENDITURES	**$1,597,309.93**	**$847,757.04**	**$1,328,181.00**	
Offsetting Revenue				
Medi-Cal	$382,590.00		$482,182.00	
Realignment	$0.00		$5,250.00	
Other	$6,601.00			
Total	**$389,191.00**	**$0.00**	**$487,432.00**	
TOTAL NET EXPENDITURES	**$1,208,118.93**	**$847,757.04**	**$840,749.00**	

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Small furniture and equipment $2,000 Computer and software $3,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Contract Psychiatry $140,000

CSS Project 5: Community Corrections Forensic FSP

Project Description

BHS's Justice and Decriminalization Unit works in partnership with San Joaquin County Jail, Correctional Health Services, the Collaborative Court System, the Probation Department, and other justice agencies, to provide a full spectrum of mental health services to consumers who are engaged by the criminal justice system. Unit staff work in collaboration with the justice system to reduce the criminalization of the mentally ill. Services include assessment, identification, outreach, support, linkage, and interagency collaboration in the courtroom and to supervising Probation Officers to help ensure a successful reentry and transition into the community for justice-involved individuals. Program activities align with the objectives of the Stepping Up Initiative, a national program for reducing incarcerations for people with serious mental illnesses. FSP programming is available for clients that meet the State's eligibility criteria and are among the following target populations.

Target Population 1: Re-entry Population

- *Justice-involved Adults 18 and over,* with serious and persistent mental illnesses who are being treated by Correctional Health Services within the San Joaquin County Jail and are within 30 days of release into the community.

Target Population 2: Forensic or Court Diversion Population

- *Justice-involved Adults 18 and over,* with a diagnosed mental illness or co-occurring substance use disorder, who are participating in problem-solving, collaborative courts in San Joaquin County or other formal diversion program.

Project Components

There are several FSP teams working with justice-involved adults who have serious mental illnesses.

1. **Intensive FSP**
   BHS contracts with two community partners to provide intensive FSP programming using an Assertive Community Treatment program model to engage justice-involved clients with a historic reluctance to engage in treatment services. The Intensive FSP program for justice involved individuals with serious mental illnesses is described as CSS Projects #8 in order to better define and account for the specialized services provided by these teams.

2. **Standard FSP**
   Forensic FSP Team

Clients Served within the Community Corrections FSP Program

Client Demographics:

Community Corrections FSP Program 2017-2018 N=303		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	18	6%
▪ Adults	280	92%
▪ Older Adults	5	2%
Gender Identity		
▪ Female	29	10%
▪ Male	274	90%
Race/Ethnicity		
▪ African American	66	22%
▪ Asian / Pacific Islander	31	10%
▪ Hispanic/Latino	79	26%
▪ Native American	8	3%
▪ White/Caucasian	94	31%
▪ Other / Not-Identified	25	8%
Linguistic Group		
▪ English	276	91%
▪ Spanish	6	2%
▪ Other, Asian	8	3%
▪ Arabic or Farsi	0	0%
▪ Other non-English	13	4%

Cost per Client:

Number Served	Total Expenditures
303	$1,534,037
Average Annual Cost	**Average Monthly Cost**
$5,063	$422

Client Projections:

BHS projects that the number and composition of Community Corrections FSP clients served in 2017-2018 will remain relatively consistent for FY 2019-2020. No significant program expansions or contractions are predicted.

CSS: FSP-Community Corrections FSP

Cost Center(s): 6360
RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	1.85			$227,902.00	$107,654.00
Deputy Director BHS- Clinical	0.20			$30,101.00	$16,028.00
Mental Health Clinician I	2.00			$130,334.00	$71,145.00
Mental Health Clinician III	0.85			$76,621.00	$43,978.00
Mental Health Specialist II	2.00			$104,845.00	$69,883.00
Office Assistant	1.00			$35,027.00	$31,171.00
Office Assistant Specialist	1.00			$37,690.00	$32,472.00
Psychiatric Technician	0.25			$11,897.00	$8,918.00
Psychiatrist	0.40			$87,189.00	$30,202.00
Sr. Nurse Practitioner	0.27			$32,194.00	$12,682.00
Sr. Office Assistant	1.00			$43,618.00	$31,020.00
Substance Abuse Counselor II	1.00			$41,350.00	$34,260.00
				$0.00	$0.00
				$858,768.00	**$489,413.00**
Total	11.82			**$1,348,181.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$430,881.08	$34,007.89	$112,656.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$718.22		$3,200.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00	$77,412.31	$0.00
CONTRACTED SERVICE PROVIDER	$4,576.36		$70,000.00
ADMINISTRATIVE / INDIRECT	$103,879.50	$1,385.78	$0.00
PERSONNEL COSTS	$682,441.86	$572,736.98	$1,348,181.00
TOTAL GROSS EXPENDITURES	**$1,222,497.02**	**$685,542.96**	**$1,534,037.00**
Offsetting Revenue			
Medi-Cal	$397,296.00		$423,122.00
Realignment	$0.00		
Other	$10,640.00		$1,340.00
Total	**$407,936.00**	**$0.00**	**$424,462.00**
TOTAL NET EXPENDITURES	**$814,561.02**	**$685,542.96**	**$1,109,575.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Contract Psychiatry $70,000

CSS Project 6: InSPIRE FSP

Project Description

The Innovative Support Program in Recovery and Engagement (InSPIRE) program serves individuals between the ages of 18-59 who are hesitant or resistant to engaging in mental health treatment. InSPIRE strives to find additional pathways to mental health services for hesitant or reluctant clients to improve individual well-being and create a safer community. A key element of InSPIRE is *Enthusiastic Engagement*.

Enthusiastic Engagement can be defined by daily contacts, to build rapport and provide a framework for voluntary mental health treatment. The goal is to engage clients, improve client stability, self-sufficiency, maintain engagement in outpatient treatment services, support placement in safe and stable housing environments, and provide individualized safety plans for clients and their family as needed.

Target Population

- *Adults,* between the ages of 18-59 (some exceptions) who have a serious mental illness and are substantially deteriorating, gravely disabled, or unable to care for themselves. InSPIRE clients may pose a serious risk to themselves or others, have a history of reluctance to engage in traditional mental health treatment, may have a history of multiple living situations, may have co-occurring disorders, or may have a history with law enforcement.

Project Components

- There is one InSPIRE FSP team.
- This team provides *Intensive FSP* services for adults.

Clients Served within the InSPIRE FSP Program

Client Demographics:

InSPIRE FSP Program 2017-2018 N=30		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	29	10%
▪ Older Adults	1	0%
Gender Identity		
▪ Female	9	3%
▪ Male	21	7%
Race/Ethnicity		
▪ African American	8	3%
▪ Asian / Pacific Islander	1	0%
▪ Hispanic/Latino	0	0%
▪ Native American	3	1%
▪ White/Caucasian	18	6%
▪ Other / Not-Identified	0	0%
Linguistic Group		
▪ English	29	10%
▪ Spanish	0	0%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	1	0%

Cost per Client:

Number Served	**Total Expenditures**
30	$723,620
Average Annual Cost	**Average Monthly Cost**
$24,121	$2,010

Client Projections:

BHS projects that the number and composition of InSPIRE FSP clients served in 2017-2018 will remain relatively consistent for FY 2019-2020. No significant program expansions or contractions are predicted.

CSS: FSP-InSPIRE FSP

Cost Center(s): 6377
RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	0.30			$33,871.00	$24,771.00
Mental Health Clinician I	2.00			$132,038.00	$92,626.00
Mental Health Outreach Worker	2.00			$76,302.00	$79,096.00
Mental Health Specialist II	2.00			$104,083.00	$74,789.00
Psychiatric Technician	1.00			$46,705.00	$22,839.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
	7.30			$0.00	$0.00
				$392,999.00	**$294,121.00**
Total				**$687,120.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$62,297.14	$14,348.92	$34,500.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$363.08		$2,000.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$42,821.42		
PERSONNEL COSTS	$398,458.61	$277,371.81	$687,120.00
TOTAL GROSS EXPENDITURES	**$503,940.25**	**$291,720.73**	**$723,620.00**
Offsetting Revenue			
Medi-Cal			$129,622.00
Realignment			
Other			
Total	**$0.00**	**$0.00**	**$129,622.00**
TOTAL NET EXPENDITURES	**$503,940.25**	**$291,720.73**	**$593,998.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Small furniture and equipment $2,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CSS Project 7: Intensive Adult FSP

This Intensive Adult FSP will work with adult consumers, aged 18 and older, with serious and persistent mental illnesses or co-occurring substance use disorders that are at risk for institutionalization. Intensive Adult FSP Program services will use an Assertive Community Treatment (ACT) Model to provide team based services that produce positive outcomes and reduce the need for hospitalizations or institutionalization.

ACT is an evidence based program designed to support community living for individuals with the most severe functional impairments associated with serious mental illnesses. The ACT model utilizes a multi-disciplinary team, which is available around the clock, to deliver a wide range of services in a person's home or community setting. Additional information regarding Assertive Community Treatment can be found through:

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345
  - https://store.samhsa.gov/shin/content/SMA08-4345/EvaluatingYourProgram-ACT.pdf
  - https://www.centerforebp.case.edu/client-files/pdf/act-dacts.pdf (Fidelity Criteria)

Target population

- *Adults,* between the ages of 18-59 (some exceptions) who have a serious mental illness and are substantially deteriorating, gravely disabled, or unable to care for themselves. The target population for the program is consumers who are at risk of acute or long term locked facility placement and/or have had multiple failed transitions from locked facilities to lower level of care. Intensive Adult FSP clients may pose a serious risk to themselves or others, may have co-occurring disorders, and/ or may have other chronic health concerns.

Project Components

- There will be two Intensive Adult FSP teams.
- Teams provide *Intensive FSP* services for adults.

2019 Implementation Update: A Request for Proposals was released for this project in fall 2018. Following a review of submissions two organizational providers were identified to implement this program. Program services are anticipated to launch in 2019.

CSS: Intensive Adult FSP

Cost Center(s): 6355
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total					**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00	$0.00	$1,500,000.00
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$0.00
	$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$1,500,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$1,500,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Contracted FSP services - Two providers

CSS Project 8: Intensive Justice Response FSP

This Intensive Adult FSP will work with adult consumers, aged 18 and older, with serious and persistent mental illnesses that have co-occurring substance use disorders. Intensive Justice Response FSP Program services will use an Assertive Community Treatment (ACT) Model to provide team based services that produce positive outcomes and reduce re-offending.

This program will provide a range of mental health treatment services within the ACT model, including case management and cognitive behavioral interventions to address criminogenic thinking with an emphasis on antisocial behaviors, antisocial personality, antisocial cognition, and antisocial associations; and lifting up protective factors associated with family, meaningful activities, or social connections. Other anticipated program services include substance use disorder treatment services; housing support services; and re-entry coaching and support.

Additional information regarding Assertive Community Treatment can be found through:

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345
  - https://store.samhsa.gov/shin/content/SMA08-4345/EvaluatingYourProgram-ACT.pdf
  - https://www.centerforebp.case.edu/client-files/pdf/act-dacts.pdf (Fidelity Criteria)

Target population

- *Adults,* between the ages of 18-59 who have a serious mental illness. The target population for this project is adults, between the ages of 18-59 who have a serious mental illness; may pose a serious risk to themselves or others; have a history of reluctance to engage in traditional mental health treatment services; and have a history of repeated contact with law enforcement with multiple involuntary holds (CA Penal Code §5150). Some participants may have more serious offense histories, including violent crimes.

Project Components

- There will be two Intensive Justice Response FSP teams.
- Teams provide *Intensive FSP* services for adults.

2019 Implementation Update: A Request for Proposals was released for this project in fall 2018. Following a review of submissions two organizational providers were identified to implement this program. Program services are anticipated to launch in 2019.

Additional funds are being solicited from Department of State Hospitals to expand capacity and to serve additional clients. If awarded, MHSA funds will be leveraged for the required county match funds.

CSS: FSP-Intensive Justice Response FSP

Cost Center(s): 6365
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total					**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00	$0.00	$1,500,000.00
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$1,500,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$1,500,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Contracted FSP services - Two providers, $200,000 for Match to Department of State Hospitals Grant

CSS Project 9: FSP Housing Empowerment Services

Project Description

Permanent supportive housing programs offer voluntary, flexible supports to help people with psychiatric disabilities choose, get, and keep housing that is decent, safe, affordable, and integrated into the community. Housing Empowerment Services helps mental health consumers enrolled in an FSP to attain and retain permanent housing. Supportive services empower consumers to live independently within their homes and communities.

Project Goal*: The overall goal of the program is to increase the numbers of mental health consumers who have safe, stable and affordable permanent housing. The measurable goal of this project is to increase the capacity of participants to maintain stable housing over time.*

The project is intended to result in:

- Increases in residential stability among mental health consumers;
- Reductions in incidences of homelessness among mental health consumers;
- Increased satisfaction with housing among mental health consumers;
- Increased number of housing units available to mental health consumers;
- Reductions in hospitalizations among mental health consumers

Target Population

The target population will be seriously mentally ill adults (ages 18 and older) enrolled in an FSP program and referred by BHS and/or their families. Participants will have symptoms of serious mental illness and be at risk of homelessness, chronic housing instability, mental health crisis, and/or hospitalization. A large portion of the target population is anticipated to have co-occurring mental health and substance abuse disorders.

Priority will be to serving individuals who are homeless, frequent users of crisis and emergency services, and/or those who have a chronic history of housing instability. In keeping with the County's MHSA Plan, the project will also provide services to unserved, underserved, and inappropriately served populations in San Joaquin County including African-American, Latino, Muslim/Middle Eastern, Native American, Southeast Asian, and Lesbian, Gay, Transgender and Bi-Sexual (LGBT) populations. Participation in services provided under this project will be voluntary.

Project Components

The Housing Empowerment Services project is based on the Evidence-Based Practice Kit on Permanent Supportive Housing issued by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). (For more information, see: http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.)

The project is a partnership between BHS and the contractor(s). BHS provides all mental health services, including assessments, treatment plans and case management services. Selected contractor(s) provide:

1. Individualized Consumer Interviews: Conduct individual interviews with each consumer to determine their preferences for location of housing (specific city or neighborhood), type of housing desired (independent, shared with roommates), desired proximity to services, transportation needs, and cultural and other preferences to assist in locating suitable housing. The interview will also be used to collect information on consumers' rental history, income, and financial situation.

2. Individualized Housing Stabilization Plans: Information collected will form the foundation of Housing Stabilization Plans, which will address both housing needs and recommended voluntary support services related to maintaining permanent housing. Contractor staff will work in partnership with FSP staff to encourage consumer participation in services designed to achieve the goals of the Housing Stabilization Plan.

   Housing Stabilization Plans will focus on identifying the minimal support necessary for the consumer household to achieve housing stability. Plans that indicate the need for continuing support will be reviewed at least every three months.

   Periodic reviews of needs and progress toward stabilization will be completed at least every three months for households requiring extended support. Contractor staff will make monthly contact with assisted households during their enrollment with an FSP. Forms used for periodic reviews will be designed to track progress toward consumer-established goals.

3. Housing Related Support Services designed to increase consumer's ability to choose, get and keep housing:
   a. Help consumers search for suitable scattered site housing, complete housing applications and meet with landlords to discuss possible concerns.
   b. Assist consumers in increasing independent living skills focusing on housing stability, such as paying rent on time, managing money, locating community amenities, buying furnishings and household goods, and maintaining the cleanliness of the apartment.
   c. Provide at least four informational presentations to consumers and family members on issues related to fair housing laws, tenant rights and responsibilities, landlord/tenant conflict resolution, and resolving problems with neighbors.
   d. Provide assistance for consumers in moving their furniture and belongings into their new homes.

4. Financial Assistance for Consumers: Provide financial assistance with rental deposits, initial months' rent, critical utility payments, essential furnishings, and property damage coverage in

order to sustain and/or maintain stable housing in urgent situations. Contractor will submit payments for rental deposits, initial months' rent, and property damage coverage directly to landlords; subsequent assistance, as warranted and approved through the assessment process and continued re-evaluation of consumer needs, will also be made directly to landlords. Other payments will be made directly to vendors on behalf of enrolled consumers.

5. Housing Standards: Housing for each consumer will be decent, affordable and safe. Contractor will conduct property inspections prior to providing housing assistance. Determination of Housing Quality Standards will be based on standardized forms used by the federal Department of Housing and Urban Development (HUD). All housing options will also meet federal and local codes for safety and habitability. Resources will not be used to provide housing assistance in facilities that do not meet local codes or that compromise consumer health and/or safety. In keeping with identified best practices, all leases signed by consumers will be required to be standard, written rental agreements, and consumers and landlords would retain all normal rights of lease extension/termination; assistance will not be provided without a valid rental agreement in place.

CSS: FSP-Housing Empowerment Services

Cost Center(s): 6385
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
Total				**$0.00**	**$0.00**
				$0.00	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00	$379,889.39	$622,869.00
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00	$38,086.10	$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$417,975.49**	**$622,869.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$417,975.49**	**$622,869.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CVLHIC Choice Housing $622,869

CSS Project 10: High-Risk Transition Team FSP

This project will provide services to individuals being discharged from inpatient hospitals, crisis residential placements, or other acute care facilities (including out-of-county placements) as they transition back to the community with a goal of avoiding re-emergence of symptoms and readmission to a psychiatric hospital. The target population for this program is individuals with serious mental illness who are: (1) disconnected from the mental health system of care and have minimal knowledge of how to access resources, and/or (2) are considered at high risk of symptom re-emergence or readmission due to their level of engagement or understanding of the mental health system of care.

Target Population

Individuals enrolled in FSP programs or eligible for enrollment in FSP programs due to symptom severity. Most participants will have one or more failed transitions from a higher level of care into the community.

Program Components

BHS will contract with an Organizational Provider to conduct outreach with referred program participants, assess client needs, and conduct intensive case management and provide 24/7 wraparound supports as needed to prevent the reemergence of symptoms or readmission to a psychiatric facility. Services will be offered for 90 -120 days depending on the assessed client needs. Services should be provided through an Assertive Community Treatment (ACT) team approach – by a range of professionals with differing life skills and professional competencies to meet client needs.

- Outreach: Meet with clients while they are still in an inpatient hospital, crisis placement, or other acute care facility. Visit on a daily basis prior to discharge to establish rapport, complete a client assessment, and develop a case plan.
- Assessment: Develop an assessment of client needs and strengths. Include both long term and short term mental health needs. Include assessment of alcohol and other drugs.
- Discharge Planning: Work with BHS staff to develop suitable housing placement upon discharge. For some clients this may include developing a plan to reunify them with their families.
- Continuing Care Planning: Work with client and or family members to develop a plan for continued engagement in treatment. This may include obtaining assistance with needed medications or arranging transportation to appointments.
- Client Engagement: Provide frequent, low demand contacts with clients where they live or are most comfortable.
- Intensive Case Management: Assist clients in accessing primary and behavioral health care services, peer-based services, financial, educational, prevocational, rehabilitative or other community based services and supports needed by clients to meet their personal goals.
- Provide 24/7 “on-call” services for clients in crisis.

CSS: FSP-High-Risk Transition Team

Cost Center(s): 6323
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
Total				**$0.00**	**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00	$0.00	$720,000.00
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$720,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$720,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP 2019-20 $720,000

CSS Project 11: FSP Adult Residential Treatment Services

Project Description

The Adult Residential Treatment Services (ARTS) program will provide long-term transitional housing with assisted living services to FSP consumers who are not able to live independently or in a supported housing environment. ARTS are rehabilitative services provided in non-institutional residential settings licensed as Social Rehabilitation Facilities under the provisions of the California Code of Regulations. ARTS will provide long-term interventions (18-24 months) in order to support and address the needs of individuals demonstrating severe impairment in general social functioning. Target program participants are adults and older adult FSP clients who require assistance with daily living, or are otherwise unable to maintain and manage treatment in more independent settings.

Program Requirements:

BHS will partner with one or more Adult Residential Treatment Service provider to provide housing and supportive services to adults, ages 25 and older with serious and persistent mental illnesses that require assistance with daily living activities including self-care and hygiene, meal preparation, housekeeping/chores, and medication maintenance. A minimum ongoing caseload of 15 consumers shall be housed at any one time.

The purpose of the program is to facilitate a safe and timely transition from a higher level care facility (for example a crisis residential facility, psychiatric health facility, or an Institution for Mental Diseases) to a community home-like setting. ARTS services may also be used to stabilize an individual to prevent placement in a higher level of care.

The Adult Residential Treatment Services must meet all license and certification requirements established by the Department of Social Services, Community Care Licensing.

Per state licensing requirements, services will include:

- Provision and oversight of personal and supportive services
- Assist with self-administration of medication
- Provide three meals per day plus snacks
- Housekeeping and laundry
- Transportation or arrangement of transportation
- Activities
- Skilled nursing services as needed

Program Components:

Provide ARTS for individuals with severe and persistent mental illnesses who are able to participate in community –based programs but require the support of therapeutic and counseling professionals to avoid transitioning to a higher level of care. It is expected that residents will move towards a more independent living setting within approximately nine (9) months to twenty-four (24) months from the date of their admission.

CSS: FSP-Adult Residential Treatment Services

Cost Center(s): 6323
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total					**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00	$0.00	$1,000,000.00
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$1,000,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$1,000,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP 2019-20 $1,000,000

General System Development Programs

"General System Development Service Category" means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plans under which the County uses Mental Health Services Act funds to improve the County's mental health service delivery system for all clients and/or to pay for specified mental health services and supports for clients, and/or when appropriate their families. *CA Code of Regulations §3200.170*

San Joaquin County provides funding for ten System Development projects, see list below. Project activities that provide mental health services and supports for clients entering, enrolled into, or transitioning out of full service partnership programs are included on a pro-rated basis to meet the requirement that the majority of CSS funds benefit and support Full Service Partnership activities. Funded projects include:

Outreach and Engagement

- Mental Health Outreach and Engagement
- Mobile Crisis Support Team
- Peer Navigation

General System Development

- Wellness Center
- Project Based Housing
- Employment Recovery Services
- Community Behavioral Intervention Services
- Housing Coordination Services
- Crisis Services Expansion
- System Development Expansion

CSS Project 12: Mental Health Outreach & Engagement

Expanded Mental Health Engagement services reaches out to individuals with mental illnesses who are unserved by the mental health system and to individuals for whom disparities in access to treatment are prevalent. Mental Health Engagement services will conduct brief outreach activities to engage individuals with mental health illnesses and link them into specialty mental health services. Peer partners, or outreach workers, will conduct targeted outreach to consumers of unplanned services, who meet the target population criteria and for whom there is a risk that they will not return for follow-up treatment. Outreach workers will provide information on available treatment services and the benefits of recovery within the cultural context of the individual and their family or community.

The goal of the project is to retain consumers of specialty mental health services in planned, outpatient treatment services. All consumers referred to Specialty Mental Health Engagement services are required to have an evaluation for specialty mental health care services through San Joaquin County Behavioral Health Services. Evaluations and referrals may be received through any of the BHS specialty mental health outpatient clinics or 24-hour crisis services, including the mobile crisis team, inpatient psychiatric facility, and crisis residential services.

Target populations

- *Unserved Individuals,* with an emphasis on individuals living in geographic areas with fewer mental health services and Hispanic and Latino neighborhoods to increase utilization of specialty mental health services amongst individuals with mental illness.
- *Inappropriately Served Consumers,* as evidenced by disproportionately high rates of participation in crisis or emergency services (compared to rates of participation in scheduled outpatient treatment services) including Native American and African American consumers.
- *Homeless Individuals,* including individuals that are living in a place not intended for human habitation, in an emergency shelter, in transitional housing, or are exiting a hospital, jail, or institution and do not have a residence in which to return and lack the resources or support networks to obtain housing.
- *Justice-involved Consumers*, including individuals released from jail or prisons with diagnosed mental illnesses.
- *Linguistically- and Culturally-Isolated Consumers,* for whom English is not their first language, and/or is not the first language of their parents, caregivers, or guardians.
- *Individuals with serious mental illnesses who are LGBT, Veterans, have developmental disabilities, or other experiences which may isolate them from the existing system of care,* including any individual who is not well-engaged by the outpatient specialty mental health clinics, and not otherwise eligible for FSP program services (i.e. lower acuity or need).

Mental Health System Outreach and Engagement

- *Provide Case Management, Engagement and Support Services* for individuals with co-occurring SMI and developmental disabilities, older adults and veterans living alone under isolated conditions who are suffering from untreated mental illnesses, including depression, grief, loneliness, post-traumatic stress disorder, or who are experiencing a loss of mobility or independence.
  - Engage and link individuals to public mental health system.
  - Provide screening, referrals and support to link participants to additional services and supports, especially as pertaining to health and safety needs.
  - Provide one-on-one support, connection and engagement to reduce depression.
  - Facilitate access to support groups at senior, veterans, and community centers.
  - Conduct two to four home visits to each participant on a monthly basis (seniors only).
  - Match funding for SAMHSA Block grant providing case management services for homeless individuals with SMI.

- *Consumer and family engagement and advocacy* helps consumers and family members navigate the system, helps consumers understand their rights and access to services, including dispute resolution. All providers (staff, contractors, and volunteers) serve as a liaison between consumers and family members and the mental health system of care. Specific activities include:
  - Family advocacy
  - Veteran outreach and engagement

CSS: O&E-Mental Health Outreach & Engagement

Cost Center(s): 6318
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Mental Health Outreach Worker	5.38			$199,409.00	$69,714.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$199,409.00	**$69,714.00**
Total				**$269,123.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00	$312,904.39	$235,194.00
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$269,123.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$312,904.39**	**$504,317.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$312,904.39**	**$504,317.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Veterans Services Office $160,000, Central Valley Low Income Housing Corp. $75,194

CSS Project 13: Mobile Crisis Support Team

Project Description

Mobile Crisis Support Teams (MCSTs) provide on-site mental health assessment and intervention within the community for individuals experiencing mental health issues and to avert a mental health related crisis. MCST help avert hospitalizations and incarcerations by providing early interventions to individuals who would not otherwise be able to seek help at traditional service locations.

MCSTs transition individuals to appropriate mental health crisis interventions in a timely fashion, reducing dependency on law enforcement and hospital resources. Comprised of a clinician and a peer- or parent-partner, MCSTs provide a warm handoff to services and help educate and introduce individuals and their family to the most appropriate services in a calm and supportive manner.

Target Population

- Individuals who are known to have serious mental illness and are substantially deteriorating or experiencing an urgent mental health concern.

- Individuals who are suspected of having a serious mental illness who may be unconnected to a mental health care team.

Project Components

- BHS operates four mobile crisis support teams.
- Services are available daily (Monday – Sunday), and into the evening hours most days of the week.

Mobile Crisis Support Teams conduct same day and follow-up visits to individuals that are experiencing a mental health crisis and require on-site, or in-home, support and assistance. MCSTs conduct mental health screenings and assessments to determine severity of needs and help transition individuals into routine outpatient care services.

CSS: O&E-Mobile Crisis Support Team

Cost Center(s): 6389
RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Mental Health Clinician I	4.00			$268,036.00	$195,376.00
Mental Health Clinician II	2.00			$153,969.00	$94,934.00
Mental Health Clinician III	1.14			$112,147.00	$58,812.00
Mental Health Outreach Worker	6.75			$248,619.00	$160,622.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$782,771.00	**$509,744.00**
Total	13.89			**$1,292,515.00**	
Overtime				$15,177.00	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$214,337.08	$12,807.46	$24,184.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		$1,000.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$101,081.39		
PERSONNEL COSTS	$874,149.27	$600,046.24	$1,307,692.00
TOTAL GROSS EXPENDITURES	**$1,189,567.74**	**$612,853.70**	**$1,332,876.00**
Offsetting Revenue			
Medi-Cal	$80,764.00		$151,396.00
Realignment	$0.00		
Other	$376,103.00		$317,654.00
Total	**$456,867.00**	**$0.00**	**$469,050.00**
TOTAL NET EXPENDITURES	**$732,700.74**	**$612,853.70**	**$863,826.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a mobile crisis support mental health program.

Brief description of items included in Non-Recurring Costs:

Small equipment $1,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CSS Project 14: Peer Navigation

Project Description

The Peer Navigation program will serve TAYs, Adults, and Older Adults recovering from a mental health crisis. The program provides recovery-focused post-crisis intervention, peer support, navigation and linkages to community services and supports. Peer Navigators will work with individuals recently served by 24-hour crisis response services, including the Crisis Unit, Crisis Stabilization Unit, Crisis Residential Facility, the Post-PHF Clinic, and the Mobile Crisis Support Team. Peer Navigators will provide a warm and caring follow-up to the crisis service and help ensure that there is appropriate follow-up care, including any necessary safety plans. Peer Navigators will also provide support and education to individuals and their family members to help prevent a relapse back into crisis.

Peer Navigators have lived experience in mental health recovery and are capable of meaningfully helping others despite their disabilities with an approach based on mutual experience.

Project Goal: *Assist individuals with serious mental illnesses and their families to gain access to specialty mental health care services and community supports.*

Project Components

BHS will work with one or more community partners to develop a Peer Navigation Program through an RFP process. Community partners will hire and train individuals, with lived experience in mental health recovery, to serve as Peer Navigators. Community Partners will use an evidence based curriculum to train Peer Navigators. Some training activities shall occur in partnership with BHS, in order to ensure that Peer Navigators are familiar with BHS services. Examples of curriculum include:

- Latino Peer Navigator Manual, developed by the Chicago Health Disparities Project
- African American Peer Navigator Manual, developed by the Chicago Health Disparities Project

Program partners will also develop (or update) a set of resource guides and train peer navigators on the resources that are available in San Joaquin County and to BHS clients. Examples of likely resources or support services that peer navigators should be prepared to discuss include housing, food pantries, primary health care services, and transportation. Peer Navigators should also receive training on how to use the County's 211 telephone information and referral service.

Peer Navigation teams will work with BHS Crisis Services to engage clients following a crisis encounter. Duties and responsibilities of the Peer Navigators may include but are not limited to:

- Provide warm outreach and engagement to clients following a crisis episode
- Provide information about community services available to support consumers
- Provide education on mental illnesses and recovery opportunities
- Provide information on client rights

- Assist clients in developing a plan to manage their recovery – this should include a safety plan to prevent relapse and a Wellness Recovery Action Plan to identify longer term recovery goals and strategies for maintaining recovery
- Encourage compliance in the treatment plan developed by the client and their clinical team
- Encourage clients to attend any follow-up appointments, and recommended groups or activities

Skills and Competencies:

- Lived experience in mental health recovery
- Reflective Listening
- Motivational Interviewing
- Wellness Recovery Action Planning (WRAP)
- Strong interpersonal skills
- Ability to maintain a self-care plan

CSS: O&E-Peer Navigation

Cost Center(s): 6323
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total					**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00	$0.00	$300,000.00
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$300,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$300,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP 2019-20 $300,000

CSS Project 15: Wellness Center

Project Description

Wellness Centers are consumer-operated programs that provide an array of recovery support services. Wellness Centers provide classes and information on services and supports available in the community, self-help and peer-support group activities, and trainings and workshops to promote long term recovery and well-being on a variety of topics: from positive parenting, to nutrition and active lifestyles, to job development skills. Wellness Centers provide scheduled and drop-in services and programming that is respectful and representative of the diversity of consumer members.

Project Goal*:*

The primary objectives for this program will be to:

- Provide a consumer-driven self-help service center in close collaboration with consumers, family members and BHS.
- Increase opportunities for consumers to participate in activities that promote recovery, personal growth and independence.
- Increase leadership and organizational skills among consumers and family members.

Target Population

The target population is consumers with mental illness and their family members and support systems.

Project Components

The Wellness Center will provide the following services:

- *Consumer Leadership:* Foster leadership skills among consumers and family members, and include the use of consumer surveys to determine necessary training and supports to assist consumers and family members in providing leadership. Wellness Center(s) will develop and maintain:
  - Consumer Advisor Committee
  - Consumer Volunteer Opportunities
- *Peer Advocacy Services:* Peer Advocates or Wellness Coaches listen to consumer concerns and assist in the accessing of mental services, housing, employment, child care and transportation. Peer Advocates or Wellness Coaches train consumers to provide self-advocacy and conflict resolution. Peer Advocates or Wellness Coaches address day to day issues consumers face such as life in board and care homes and negotiating the mental health system to obtain services and understanding medications. Issues and information addressed include:
  - *Legal Advocacy:* Information regarding advanced directives and voter registration and securing identification documentation
  - *Housing Information and Advocacy:* Information on housing resources will be provided. Consumers will be assisted in developing skills needed in finding affordable, well maintained housing options and alternatives, such as finding compatible roommates.
  - *Employment Advocacy*: Information on employment, the impact of SSI benefits, available

resources and programs and resume and interview preparation will be provided. Assistance will be given in finding suitable clothing and transportation for job interviews. Services will be provided in collaboration with the BHS Career Center.

- *Childcare Advocacy:* Childcare advocacy will be available to consumers who have children under the age of 13 and will include the provision of information, assessing problems of access and providing vouchers to pay for childcare when needed to access mental health services, medical services or attend a job interview.
- *Transportation Advocacy:* Consumers will be trained on accessing available public transportation options. When situations arise where there are no public transportation options, the Center will provide transportation to stakeholder activities, clinic appointments, medical appointments, peer group classes, employment interviews and urgent situations.

- *Peer-Led Classes and Coaching:* The average group class size should be five to seven consumers. The following consumer-led services will be provided at the Wellness Center:

  - Independent Living Skills classes to teach cooking skills, budgeting, banking, nutrition, healthy living and exercise, grocery shopping, and use of community resources such as the library and the Food Bank.
  - Coping skills classes to teach time management, personal safety, communication skills, medication information, socialization skills, decision making and goal oriented task completion.
  - Serenity exploration to allow consumers to explore individual spirituality and growth as part of recovery.
  - Wellness and Recovery Action Planning (WRAP).
  - Computer skills coaching to assist peers in the use of computers and internet access. Computers and internet access will be available at the center.

- *Outreach Services:* Outreach services will be provided to consumers and family members to increase awareness of the availability of the Wellness Center and to encourage the use of its services. Outreach efforts will include unserved, underserved and inappropriately served populations. Cultural activities will be organized on a regular basis to introduce new community members to the Wellness Center.

- *Volunteer Program*: A volunteer program for peer advocates and peer group class facilitators will be developed and maintained. The volunteer program may also include the development of a speakers' bureau to address stigma and discrimination and to relay stories of those recovering from mental illness.

CSS: GSD-Wellness Center

Cost Center(s): 6300
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
Total				**$0.00**	**$0.00**
				$0.00	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$471,719.11	$278,286.27	$519,403.00
ADMINISTRATIVE / INDIRECT	$43,805.81		
PERSONNEL COSTS			$0.00
TOTAL GROSS EXPENDITURES	**$515,524.92**	**$278,286.27**	**$519,403.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$515,524.92**	**$278,286.27**	**$519,403.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Peer Recovery Services $519,403

CSS Project 16: Project Based Housing

Project Description: BHS, in partnership with the Housing Authority of San Joaquin, will create Project-Based Housing Units dedicated towards individuals with serious mental illnesses for a period of twenty years.

Under federal regulations, public housing agencies operate and distribute housing choice vouchers (formerly Section 8). Up to 20% of the vouchers may be set aside to specific housing units. Project-Based Housing Units are housing units that have vouchers attached to units.

Under state regulations, MHSA funding may be used to create Project-Based Housing Units, provided that the units have the purpose of providing housing as specified in the County's approved Three-Year Program and Expenditure Plan and/or Update for a minimum of 20 years.

General System Development Funds may be used to create a Project-Based Housing Program which is defined as a mental health service and support. *CA Code of Regulations §3630(b)(1)(J)*

The regulations and requirements for the creation of a Project Based Housing Program and a Capitalized Operating Subsidy Reserve were added to the California Code of Regulations in 2016, in response to the No Place Like Home Act. See: *CA Code of Regulations §36330.05; §36330.10; §36330.15;*

Project Components:

Under a partnership agreement, upon approval by the San Joaquin County Board of Supervisors and the Board of the Directors of the Housing Authority of San Joaquin, BHS and the Housing Authority shall leverage MHSA funding for the following purposes.

1) Establish a Project Based Housing Fund:
   Up to $4.1 million will be transferred to the Housing Fund for the purpose of acquisition, construction or renovation of Project Based Housing Units.

   This fund shall be an irrevocable transfer of money from San Joaquin County Behavioral Health Services to the Housing Authority of San Joaquin for the purpose of creating the following Project Based Housing Programs.
   - Crossway Residences I, located at 448 S. Center Street. The project will include 14 client apartments and one resident manager apartment.
   - Crossway Residences II, located at 421 S. El Dorado Street. The project will include 12 client apartments.
   - Park Residences, located at 32 W. Park Street. The project will include 11 client apartments and one resident manager apartment.

The total number of housing units currently in development is 37; exceeding the Three Year Program and Expenditure Plan goal of developing 34 units of housing for the mentally ill.

2) Establish a Capitalized Operating Subsidy Reserve:
   Up to $550,000 will be deposited into a County-administered account prior to occupancy of the Project-based housing. The actual amount deposited in the reserve account shall be based on the difference between the anticipated tenant portion of the rent minus revenue lost from anticipated vacancies and the estimated annual operating expenses of the Project Based Housing.
   - BHS and Housing Authority mutually acknowledge that the anticipated tenant population may require *more intensive* property management services requirements than typical for a population without serious mental illnesses. Cost projections for the estimated annual operating expenses will be based on reasonable assumptions and procurement of an onsite property management team.
   - The Operating Subsidy Reserve may also be used to repair any major damages resulting from tenant occupancy beyond normal wear and tear and other scheduled property maintenance.

3) Funding shall be used in strict accordance to Regulatory Requirements:
   Project-Based Housing purchased, constructed and/or renovated with General System Development funds shall comply with all applicable federal, state, and local laws and regulations including, but not limited to:
   - Fair housing law(s)
   - Americans with Disabilities Act
   - California Government Code section 11135
   - Zoning and building codes and requirements
   - Licensing requirements (if applicable)
   - Fire safety requirements
   - Environmental reporting and requirements
   - Hazardous materials requirements

   Project-Based Housing purchased, constructed and/or renovated with General System Development funds shall also:
   - Have appropriate fire, disaster, and liability insurance
   - Apply for rental or other operating subsidies
   - Report any violations to DHCS if a violation is discovered
   - Maintain tenant payment records, leasing records, and/or financial information

4) Eligibility and Target Population
   All tenant residents within a Project Based Housing Unit created with General System Development Funds must be diagnosed with a serious mental illness.

5) Veteran Status
   Veterans are recognized as an underserved population. BHS and the Housing Authority will work jointly to ensure that there are more housing opportunities for veterans with serious mental illnesses.

6) Term
   Project units must remain dedicated towards housing the mentally ill for a period of no less than 20 years. Upon completion of the pilot program, BHS and the Housing Authority will mutually review evaluation and program data to determine the target population of tenants from within the population of individuals with serious mental illnesses.

7) Leasing, Rental Payments and Eviction Processes
   BHS reserves the right to make tenant referrals for placement into the Project-Based Housing Units and to develop referral policies and procedures in partnership with the Housing Authority.

   Rents will be subsidized *Project-Based Housing Vouchers,* which will be assigned by the Housing Authority and shall be specific to the Unit currently being occupied. Vouchers are non-transferable, though clients may be eligible for *Housing Choice Vouchers*, following successful completion of program services.

   The Housing Authority reserves the right to make tenant evictions and to develop tenant eviction policies and procedures in partnership with BHS.

   In all instances access to housing and housing eviction policies and procedures will be guided by applicable laws and regulations including Fair Housing Laws.

   BHS and Housing Authority will meet regularly to review policies, procedures, and practices pertaining to the operations of the Project Based Housing Units created with General System Development Funds.

Prior to the release of MHSA funds, an agreement will be created between BHS and the Housing Authority and duly executed by the San Joaquin County Board of Supervisors and the Board of Directors of the Housing Authority of San Joaquin.

CSS: GSD-Project Based Housing

Cost Center(s): 6385
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total				**$0.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$181,587.94		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		$550,000.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$511,689.33	$13,144.57	$3,600,000.00
ADMINISTRATIVE / INDIRECT	$67,093.93		
PERSONNEL COSTS	$29,217.99		$0.00
TOTAL GROSS EXPENDITURES	**$789,589.19**	**$13,144.57**	**$4,150,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$789,589.19**	**$13,144.57**	**$4,150,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Capitalized Operating Subsidy Reserve $500,000 and $50k for furniture purchase.

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Housing Authority of San Joaquin $3,600,000: original budget was $3.5M starting in FY18-19, vendor has requested an additional $600k for FY19-20.

CSS Project 17: Employment Recovery Services

Project Description

Supported Employment is an approach to vocational rehabilitation for people with serious mental illnesses that emphasizes helping them obtain competitive work in the community and providing the supports necessary to ensure their success in the workplace. The overriding philosophy of Supported Employment is the belief that every person with a serious mental illness is capable of working competitively in the community if the right kind of job and work environment can be found. Supported Employment is not designed to change consumers, but to find a natural "fit" between consumers' strengths and experiences and jobs in the community.

Project Goal*: The goal of this project is to increase the numbers of mental health consumers that are employed and/or involved in education.*

The project is intended to result in the following outcomes for mental health consumers participating in the project:

- Increased competitive employment among consumers;
- Increased independent living;
- Increased educational involvement;
- Increased self-esteem; and
- Increased satisfaction with finances.

Target Population

The target population will be seriously mentally ill adults (ages 18 and older) that are enrolled in or are transitioning to or from the County's Full-Service Partnership programs and their families. Participants will have symptoms of serious mental illness and be at risk of homelessness, chronic housing instability, mental health crisis, and/or hospitalization. A large portion of the target population is anticipated to have co-occurring mental health and substance use disorders.

Project Components

The Employment Recovery Services project will be based on the *Evidence-Based Practices Kit on Supported Employment* issued by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) located at: http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365

- *Assertive Engagement and Outreach:* Make multiple contacts with consumers as part of the initial engagement and at least monthly on an ongoing basis when consumers stop attending vocational services.

- *Vocational Profiles:* Conduct individualized interviews with each consumer to determine their preferences for type of employment, educational and work experiences, aptitudes and

motivation for employment. Vocational profiles will be consumer driven and based on consumers' choices for services. Vocational assessment will be an ongoing process throughout the consumer's participation in the program.

- *Individual Employment Plans:* In partnership with each consumer, prepare an Individual Employment Plan, listing overall vocational goals, objectives and activities to be conducted. Assist consumers with resume development and interviewing skills as needed.

- *Personalized Benefits Counseling:* Provide each consumer with personalized information about the potential impact of work on their benefits.

- *Job Search Assistance:* Help consumers explore job opportunities within one month after they enter the program. Provide job options in diverse settings and that have permanent status. Employer contacts will be based on consumers' job preferences.

- *Continuous Supports:* Provide continuous support for employed consumers that include the identification and reinforcement of success as well as coaching when concerns arise. Help consumers end jobs when appropriate and then find new jobs.

CSS: GSD-Employment Recovery Services

Cost Center(s): 6385
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total				**$0.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$154,830.80	$72,816.32	$197,372.00
ADMINISTRATIVE / INDIRECT	$14,378.24		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$169,209.04**	**$72,816.32**	**$197,372.00**
Offsetting Revenue			
Medi-Cal			
Realignment			
Other			
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$169,209.04**	**$72,816.32**	**$197,372.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

UOP Employment Recovery Services $197,372

FSP Project 18: Community Behavioral Intervention Services

Project Description

The project will provide behavioral intervention work in the community to consumers who are having a hard time managing behaviors and impulses. The services are based on the foundation and principles of Applied Behavior Analysis and intended to address behaviors or symptoms that jeopardize mental health consumers' recovery, wellness and quality of life. The interventions are not intended as a "stand alone" service. They will supplement other mental health services provided to consumers.

Project Goal: *The goal of the project is to provide behavioral interventions in order to increase mental health consumers' stability, social functioning and recovery-focused behaviors.*

The project is intended to promote long-lasting functional change among consumers by decreasing the incidence of dysfunctional and maladaptive behaviors and increasing the incidence of functional and adaptive behaviors. Successful change may result in the following outcomes among participating consumers:

- Prevention of or reductions in psychiatric hospitalizations and re-hospitalizations;
- Reduction in incidences of homelessness, disruption in housing and/or out-of-home placements; and
- Reduction of the stigma and distress experienced by many consumers as a result of maladaptive behaviors.

Target Population

The target population will be seriously mentally ill adults (ages 18 and older that are enrolled in or are transitioning to or from County's Full-Service Partnership programs and their families. Participants will have symptoms of serious mental illness and be at risk of homelessness, chronic housing instability, mental health crisis, and/or hospitalization. A large portion of the target population is anticipated to have co-occurring mental health and substance use disorders.

Project Components

The contractor will use a behavior analysis model in which procedures are systematically applied to improve socially significant behavior to a meaningful degree. Treatment strategies will be flexible and individualized. In general, treatment strategies will include instruction to increase appropriate alternative behaviors. The treatment methodology will include:

- Individualized goals developed to meet the needs of each consumer;
- Teaching skills that are broken down into manageable, easy-to-learn steps;
- Opportunities for consumers to practice each step;
- Acknowledgement of successes using a tangible reward system; and
- Continuous measurement of individual consumer progress so that treatment may be adjusted as needed.

Additional project components include:

- *Behavior Assessment (Functional Analysis):* Comprehensive assessments of each consumer's behavior will be conducted to determine target behaviors that need to be addressed, the antecedents of those behaviors, and the consequences of maintaining them. The contractor staff is expected to include BHS staff, the consumer, family members and other relevant treatment team members in the behavior assessments. Behavior assessments must be completed within 30 days of the service authorization from BHS.

- *Individual Recovery Plans (Behavior Plans):* Specific and measurable Individual Recovery Plans will be completed within 30 days of the service authorization from BHS. All Individual Recovery Plans will include:

    - Definition of the target behavior;
    - Alternative behaviors to be taught;
    - Intervention strategies and methodologies for teaching alternative behaviors;
    - Methods for collecting data on and measuring target behaviors to ensure they are being reduced; and
    - An emergency management section providing detailed instruction for staff and family members on how to address the target behavior when it reoccurs.

  Individual Recovery Plans will be coordinated with and approved by BHS.

- *Individualized Progress Reports*: Progress reports on the accomplishment of goals for each consumer will be provided to BHS on a schedule as determined by BHS, but no less than monthly. Progress reports will be based on systematic data collection and evaluation of data on each consumer's progress towards their goals.

CSS: GSD-Community Behavioral Intervention Services

Cost Center(s): 6390
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total				**$0.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$496,476.80	$303,665.60	$796,288.00
ADMINISTRATIVE / INDIRECT	$46,104.91		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$542,581.71**	**$303,665.60**	**$796,288.00**
Offsetting Revenue			
Medi-Cal	$308,248.00		$284,427.00
Realignment	$0.00		
Other	$649.00		$1,600.00
Total	**$308,897.00**	**$0.00**	**$286,027.00**
TOTAL NET EXPENDITURES	**$233,684.71**	**$303,665.60**	**$510,261.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Community Behavioral Intervention Services $796,288

CSS Project 19: Housing Coordination Services

Project Description: BHS recognizes that a safe and stable place to live is a necessary component for mental health wellness and recovery. Housing Coordination and Placement Teams will assess housing placement needs for individuals with serious mental illness and link clients to housing services and supports appropriate to the treatment needs of each consumer. Team members work with housing providers to stabilize consumers in their placements and provide regular home visits to encourage consumers to remain engaged in treatment and to take medications as prescribed.

Project Goal: *The goal of this project is to reduce the incidence of homelessness or housing instability among consumers and to increase participation in routine treatment.*

Project Components:

Project 1: Housing Referral and Linkage

Dedicated staff will coordinate housing placement recommendations for BHS consumers with serious mental illnesses. Located within the outpatient Community Adult Treatment Services division, teams manages client placement within a continuum of housing placement options. In general the task is to evaluate each client and determine the type of housing best suited to the treatment needs of the individual. Housing options will range from "intensive" such as provided by a crisis residential or adult residential care facility; to more independent or supported living options.

Project 2: Housing-based Case Management

The *Placement Team* provides case management services to consumers, for extended periods of time while placed in out of county residential enhanced board and care homes. They will work briefly with newly referred consumers, not yet open to outpatient services, until linked and stable in housing. The *Housing Coordination Team* works with clients in designated housing programs to provide socialization and rehabilitation groups and linkage to behavioral health and community resources. Both teams work closely with housing operators to ensure that placements are a good fit between the client, the program, and other tenants. Case managers work with clients to help them maintain treatment compliance, attend routine appointments, and participate in groups and socialization activities.

Project 3: Housing Stabilization Resources

MHSA funding will be used to provide "patches" to board and care and other residential care facility operators providing housing to individuals with serious mental illnesses, including consumers exiting institutions that require extra stabilization supports to prevent decompensation.

MHSA funding will be used for short-term emergency "housing stabilization funds" to assist consumers who are determined to be at imminent and immediate risk of homelessness due to displacement to procure new housing.

CSS: GSD-Housing Coordination Services

Cost Center(s): 6386
RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	0.65			$61,758.00	$30,026.00
Mental Health Clinician I	1.00			$66,019.00	$46,313.00
Mental Health Outreach Worker	0.25			$10,697.00	$7,086.00
Mental Health Specialist II	3.00			$135,739.00	$108,265.00
Mental Health Specialist III	0.50			$28,571.00	$17,774.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$302,784.00	**$209,464.00**
Total	5.40			**$512,248.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00	$8,061.56	$12,000
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		$48,750.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00	$171,780.00	$1,590,431.00
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00	$115,446.70	$512,248.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$295,288.26**	**$2,163,429.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$295,288.26**	**$2,163,429.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a housing coordination mental health program.

Brief description of items included in Non-Recurring Costs:

Purchase vehicle for consumer transport $35,000 Small furniture $1,750 Computer equipment $12,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Enhanced Care Homes $1,590,431

CSS Project 20: Crisis Services Expansion

Project Description

Through MHSA funding, BHS has expanded and enhanced crisis services. The Crisis Unit provides a 24/7 crisis response for any individual experiencing a mental health emergency in San Joaquin County. New Crisis Services fully or partially funded through MHSA funds include:

Project Components:

Project 1: Capacity Expansion

Prior to the passage of the Mental Health Services Act in November 2004, the BHS Crisis Unit operated M-F from 7am – 11pm. Staffing was limited and wait times were very long. MHSA funding created a full-service Mental Health Crisis Unit for San Joaquin County that is open 24/7, 365 days a year.

The expanded crisis unit boasts more robust staffing, reducing wait times. It has a new medication room, eliminating the need to wait for the pharmacy to open for the team to dispense medications. Services are expanded with a new triage unit, ensuring all clients receive a warm welcome and a brief screening within a timely fashion. Enhanced discharge services make it possible for clients to receive aftercare support and a warm connection to continuing services through the Outpatient Clinics. New discharge services include: post-crisis or -hospitalization transportation home, and transport to initial outpatient appointments, if necessary.

Project 2: Warm Line

The BHS Warm Line is a 24-hour service that provides consumers and their family members with 24/7 telephone support to address a mental health concern. The Consumer Support Warm-Line is a friendly phone line staffed with Mental Health Outreach Workers who provide community resources and give support and shared experiences of Hope and Recovery. Consumers and their families can obtain referrals, share concerns, receive support, and talk with a Mental Health Outreach Works who generally understands their perspective, and is willing to listen and talk with them.

Project 3: Crisis Community Response Teams (CCRT)

CCRT clinicians respond to emergency requests from law enforcement for immediate, on-site mental health crisis services, including mental health evaluations for temporary, involuntary psychiatric inpatient care in situations where the mental health consumer is a danger to self, danger to others or gravely disabled.

The CCRT also works in coordination with local hospital emergency rooms. Hospitals providing medical care may call the CCRT to request a crisis evaluation for any person at the hospital who has already been medically cleared (ready for discharge), and who may be a danger to self, others or gravely disabled due to a mental disorder. CCRT clinicians work with hospital staff to determine the appropriate level of intervention needed, including transport to a crisis stabilization unit and/or a psychiatric health facility. BHS operates two Crisis Community Response Teams. Services are available 24/7.

CSS: GSD-Crisis Services Expansion

Cost Center(s): 6395

RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	1.25			$137,652.00	$88,364.00
Chief Mental Psychiatric Technician	0.84			$56,665.00	$39,530.00
Deputy Director BHS- Clinical	0.25			$37,626.00	$20,036.00
Mental Health Clinician I	3.60			$249,205.00	$100,231.00
Mental Health Clinician II	5.58			$449,489.00	$260,603.00
Mental Health Clinician III	2.50			$247,904.00	$155,862.00
Mental Health Court Liason	0.25			$19,482.00	$10,329.00
Mental Health Outreach Worker	10.25			$421,921.00	$140,460.00
Mental Health Specialist II	6.38			$315,786.00	$149,131.00
Office Assistant	2.50			$98,650.00	$68,625.00
Office Assistant Specialist	0.25			$9,422.00	$8,118.00
Office Supervisor	1.25			$60,398.00	$42,747.00
Office Worker	0.75			$25,631.00	$1,974.00
Psychiatric Technician	2.68			$138,011.00	$44,385.00
Psychiatrist	0.08			$23,754.00	$14,029.00
Sr. Office Assistant	1.50			$64,348.00	$40,749.00
Sr. Psychiatric Technician	1.63			$105,394.00	$75,566.00
Staff Nurse III	0.25			$30,205.00	$20,941.00
Staff Nurse IV	0.20			$26,876.00	$17,555.00
Staff Nurse V Asst Nursing Dept Mgr	0.25			$35,039.00	$22,922.00
Substance Abuse Counselor II	1.00			$52,454.00	$32,102.00
				$2,605,912.00	**$1,354,259.00**
Total	43.22			**$3,960,171.00**	
Overtime				$145,000.00	
Holiday				$20,000.00	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$625,836.04	$177,992.53	$313,098.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$72,623.64		$46,100.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00	$65,247.86	
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$356,794.76		
PERSONNEL COSTS	$3,143,654.35	$2,273,047.01	$4,125,171.00
TOTAL GROSS EXPENDITURES	**$4,198,908.79**	**$2,516,287.40**	**$4,484,369.00**
Offsetting Revenue			
Medi-Cal	$2,760,053.00		$2,968,058.00
Realignment	$0.00		
Other	$112,000.00		$58,000.00
Total	**$2,872,053.00**	**$0.00**	**$3,026,058.00**
TOTAL NET EXPENDITURES	**$1,326,855.79**	**$2,516,287.40**	**$1,458,311.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support crisis program expansion.

Brief description of items included in Non-Recurring Costs:

One 4 door sedan for client transport $35,000 Small furniture and equipment $1,650 Computers and software $9,450

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CSS Project 21: System Development Expansion

Project Description

System Development Expansion Services include the outpatient clinic system that provides planned mental health treatment services (scheduled appointments). Prior to the provision of the MHSA, specialty mental health services served a smaller population of consumers. During the original CSS planning process in FY 2005/06, BHS estimated that 11,000 consumers received mental health services. Since 2004, and in accordance with MHSA, BHS has conducted assertive community outreach and engagement to increase access to mental health services amongst unserved and underserved individuals. Over the past ten years, the number of consumers served annually has increased 25%, to nearly 16,000.

MHSA funding is used to expand mental health services and/or program capacity beyond what was previously provided (*CA Code of Regulations:* § 3410 (a)(1)).

Areas of expansion include:

- Expanded range of outpatient specialty mental health services available.
- Increased program capacity to serve an estimated 5,000 additional clients.
- Enhanced consumer-friendly and culturally-competent screening and linkage to services.
- Development of consumer and family driven services, including the use of peer partners, recovery coaches, and consumer or family member outreach workers throughout the mental health system of care.
- Expanded use of nurses and psychiatric nurse practitioners to strengthen linkages between specialty mental health and primary care providers.

CSS: GSD-System Development Expansion

Cost Center(s): New TBD
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total					**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		$925,011.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00		$427,792.00
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$1,352,803.00**
Offsetting Revenue			
Medi-Cal	$0.00		$371,070.00
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$371,070.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$981,733.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Expansion of core services

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Victor Community Support Services providing ICC/CFT/IHBS services and expanded outpatient services.

VI. Prevention and Early Intervention

Overview

The Mental Health Services Act (MHSA) allocates funding for Prevention and Early Intervention (PEI) programs that help prevent the onset of emotional and behavioral disorders and mental illnesses and improve timely access to mental health services for underserved populations. PEI services include education, information, supports, and interventions for children, youth, adults, and older adults.

The purpose of prevention and early intervention programs is to prevent mental illnesses from becoming severe and disabling. Characteristics of Prevention and Early Intervention Programs are guided by regulation. At a minimum, each county must develop at least one Prevention program; one Early Intervention program; one program of Outreach for Increasing Recognition of Early Signs of Mental Illness; one Access and Linkage to Treatment Program; and one Stigma and Discrimination Reduction Program. Counties may also include one or more suicide prevention programs. (California Code of Regulations §3705)

Each program must further be designed to help create access and linkage to treatment and to be designed and implemented in such a way as will improve timely access to mental health services. This means that services must also be provided in a range of convenient, accessible, acceptable and culturally appropriate settings. (California Code of Regulations § 3735)

Finally, all PEI programs shall apply effective methods likely to bring about intended outcomes, such as the use of evidence based or promising practices. (California Code of Regulations §3740) Desired outcomes include a reduction of negative outcomes and an increase in correlated positive outcomes associated with housing, education, employment, stability, and wellness.

Negative Outcomes: Counties shall develop programs that are designed to prevent mental illnesses from becoming severe and disabling. Programs shall emphasize strategies to reduce negative outcomes that may result from untreated mental illness. (Welfare and Institutions Code § 5840)

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Prevention Program: a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The purpose of prevention programs is to bring about mental health, including a reduction in applicable negative outcomes, for individuals whose risk of developing a mental illness is greater than average. Examples of risk factors include, but are not limited to adverse childhood experience, chronic medical conditions, experience of severe trauma or ongoing stress, poverty, family conflict or domestic violence, etc. (California Code of Regulations § 3720)

San Joaquin PEI Prevention Programs – Children, Youth, and their Families

- Skill Building for Parents and Guardians
- Family Therapy for Children and Youth
- Mentoring for Transitional Age youth

Early Intervention Program: treatment and other services or interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including addressing the applicable negative consequences that may result from an untreated mental illness.

San Joaquin PEI Early Intervention Programs – Children and Youth

- Early Mental Health Services
    - CARES Foster Care Project
    - Juvenile Justice Project
- School Based Interventions
- Early Interventions to Treat Psychosis

San Joaquin PEI Early Intervention Programs – Adults and Older Adults

- Trauma Services for TAY, Adults, and Older Adults
- Recovery Services for Victims of Human Trafficking
- Recovery Services for Non-Violent Offenders
- Forensic Access and Engagement Project

Access and Linkage to Treatment Program: A set of related activities to connect children, youth, adults, and older adults with severe mental illnesses to medically necessary care and treatment, as early in the onset of these conditions as practical. Examples of Access and Linkage to Treatment Programs, include programs with a primary focus on screening, assessment, referral, telephone help lines, and mobile response. (California Code of Regulations §3726)

- Whole Person Care Project

Outreach for Increasing Recognition of Early Signs of a Mental Illness: Outreach is the process of engaging, encouraging, educating, training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. "Potential Responders" includes families, primary care providers, school personnel, community service providers, peer providers, law enforcement personnel, etc. (California Code of Regulations § 3715)

- Increasing Recognition of Mental Illnesses

Stigma and Discrimination Reduction Program: Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. Examples of Stigma and Discrimination Reduction Programs include social marketing campaigns, speakers' bureaus, anti-stigma advocacy, targeted education and trainings, etc. (California Code of Regulations §3725)

- Information and Education Campaign

Suicide Prevention: Suicide prevention programs aim to prevent suicide as a consequence of mental illness. Programs may include public and targeted information campaigns, suicide prevention networks, screening programs, suicide prevention hotlines or web-based resources, and training and education.

- Suicide Prevention with Schools
- Suicide Prevention for the Community

All MHSA funded prevention programs utilize evidence based practices. Evaluation findings from the 2016/17 and 2017/18 Fiscal Years are included in the appendix.

PEI Project 1: Skill-Building for Parents and Guardians

Community Need

Research demonstrates that some of the risk factors associated with a higher than average likelihood of developing mental illnesses include adverse childhood experiences, trauma and ongoing stress, family or domestic violence, and prior self-harm or suicide attempts. Developing ways to empower parents with the skills necessary to mitigate stress within the family unit is essential to reducing risk and building resiliency among children and youth.

Project Description

Community-based organizations will facilitate evidence based parenting classes or groups in communities throughout San Joaquin County. Parenting classes or groups will target underserved populations and be conducted in multiple languages.

Project Goal: *To prevent and reduce risk factors for mental illness and increase protective factors associated with social connectedness, parent and family resilience, and knowledge of child development.*

Project Components

Community-based organizations will convene parenting classes or groups at one or more sites within San Joaquin County. Parenting classes will address parent and family resiliency, knowledge of child development, and support pro-social interactions and social connectedness.

Potential evidence-based parenting classes include:

Nurturing Parenting Program is a series of 10-12 independent 60-90 minute lessons designed to teach parents alternatives to physical punishment and improve parenting skills, including: 1) understanding feelings; 2) alternatives to spanking; 3) communicating with respect; 4) building self-worth in children; 5) praising children and their behavior; 6) ages and stages of growth for infants and toddlers; 7) the philosophy and practices of Nurturing Parenting; 8) learning positive ways to deal with stress and anger; 9) understanding and developing family morals, values and rules; and 10) ways to enhance positive brain development in children and teens. For more details about the evidence-based Nurturing Parenting Program see: http://www.nurturingparenting.com

Strengthening Families is a 20-session program designed to engage parents in meaningful conversations about research based protective factors that mitigate the negative impacts of trauma. Protective factors include: 1) parental resilience; 2) social connection; 3) knowledge of parenting and of child and youth development; 4) concrete support in times of need; 5) children's social and emotional development; and 6) parent-child relationships. For more details about the evidence-based Strengthening Families program see: http://www.strengtheningfamiliesprogram.org

Parent Cafes is a model derived from the Strengthening Families Initiative, and is a distinct process that engages parents in meaningful conversations about what matters most – their family and how to strengthen that family by building protective factors. Parent Cafés are focused on building the 5 research based protective factors that mitigate the negative impacts of trauma. See: http://www.bestrongfamilies.net/build-protective-factors/parent-cafes/

Positive Parenting Program (Triple P) is an evidence-based 12-hour program, delivered in six 2-hour group meetings with between 8 and 12 parents. The goal of Triple P is to prevent behavioral, emotional and developmental problems by teaching parents skills to reduce parental stress and increase confidence in parenting. The success of Triple P is demonstrated by increased knowledge, skills and confidence, as measured by a Parenting Task Checklist and decreased levels of stress, over-reactivity and hostility, as measured by the Parenting Scale. For more details about the Positive Parenting Program see: http://www.triplep.net/glo-en/home/

PEI: Prevention-Skill Building for Parents & Guardians

Cost Center(s): 6397
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total				**$0.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$19,321.36	$8,988.09	$0.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$263,915.03	$165,431.41	
CONTRACTED SERVICE PROVIDER	$285,308.39	$72,412.70	$479,102.00
ADMINISTRATIVE / INDIRECT	$79,660.88	$162,788.35	$71,865.00
PERSONNEL COSTS	$73,536.22	$154,418.63	$0.00
TOTAL GROSS EXPENDITURES	**$721,741.88**	**$564,039.18**	**$550,967.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$721,741.88**	**$564,039.18**	**$550,967.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support the PEI Program.

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Catholic Charities $159,135, Parents By Choice $159,135, Child Abuse Prevention Council $160,832

PEI Project 2: Family Therapy for Children and Youth

Community Need:

Parents and families of children and youth struggling with either early signs of mental health diagnoses, or serious emotional disorders, delinquency, violence, and substance abuse have few options to address the role that family dynamics or past family trauma may contribute to current behaviors. Research demonstrates that family therapy, in conjunction with a rehabilitative approach to counterproductive family dynamics, can build and engage parent cooperation in treatment and strengthen the extent to which the family system is conducive to recovery and wellness.

Project Description:

In 2013, BHS created the Adapting Functional Family Therapy (FFT) program through MHSA Innovation funding. The project sought to determine if the better outcomes could be achieved by adapting FFT to include parent partners within the treatment regime. Overall, participant families benefitted from the intervention, though not at a significantly greater extent than FFT provided as usual. Through ongoing PEI funding, BHS will continue to provide family therapy for at risk youth and families.

Project Goal: *To reduce the incidence of serious emotional disturbances amongst children and youth by providing early therapeutic interventions to support recovery, wellness, and family strengthening.*

Project Components:

Provide family therapy and rehabilitation services for children and youth that are at risk for and/or presenting with delinquency, violence, substance use, conduct disorder, oppositional defiant disorder, disruptive behavior disorder, mood disturbances, anxiety symptoms, or trauma. Therapy, in conjunction with rehabilitation services, will be provided by a mental health clinician and paraprofessionals. Treatment goals consist of 8-15 sessions, with up to 26 sessions for serious situations.

Intervention approaches may include:

- *Motivational Interviewing.* Motivational Interviewing is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles— expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client's belief s/he can successfully make a change).
  See: http://www.integration.samhsa.gov/clinical-practice/motivational-interviewing

- *Cognitive Behavioral Therapy (CBT):* CBT focuses on the development of personal coping strategies that target solving current problems and changing unhelpful patterns in cognitions (e.g., thoughts, beliefs, and attitudes), behaviors, and emotional regulation. It is widely used in family therapy and is recognized as a successful early intervention approach for youth. See: http://www.integration.samhsa.gov/integrated-care-models/IOM_Report_on_Prevention.pdf

- *Strengthening Families*: Parents and children/youth participate in a 14 week group curriculum that includes a parenting group, child/youth group, and family group. The Strengthening Families Program (SFP) is a nationally and internationally recognized parenting and family strengthening program for high-risk and general population families. SFP is an evidence-based family skills training program found to significantly improve parenting skills and family relationships, reduce problem behaviors, delinquency and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills.

- *Skill Building, Linkage to Parent Partners:* Parents and guardians often require support and advice during difficult times. Research shows that a caring peer partner, someone with similar lived experience, is an asset to treatment interventions. Parent partners will provide coaching, mentoring, and guidance to parents and guardians of engaged youth on navigating the system, achieving case plan objectives, and discussing tips and strategies for parenting, and strengthening the family system, and reinforce skill training in family communication, parenting problem solving, and conflict management.

PEI: Prevention-Family Therapy for Children & Youth

Cost Center(s): 6393
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	0.50			$65,653.00	$35,556.00
Mental Health Clinician I	2.00			$136,969.00	$95,149.00
Mental Health Clinician III	1.00			$81,747.00	$60,588.00
Mental Health Outreach Worker	4.00			$148,678.00	$133,178.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$433,047.00	**$324,471.00**
Total				**$757,518.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$18,739.21	$13,951.52	$25,773.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$18,772.06		$2,000.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$9,975.00		
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$58,203.89	$47,036.49	$117,794.00
PERSONNEL COSTS	$292,147.73	$299,625.08	$757,518.00
TOTAL GROSS EXPENDITURES	**$397,837.89**	**$360,613.09**	**$903,085.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$397,837.89**	**$360,613.09**	**$903,085.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support the PEI Program.

Brief description of items included in Non-Recurring Costs:

Small furniture and equirpment $2,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

PEI Project 3: Mentoring for Transitional Age Youth

Community Need
Research demonstrates that some of the risk factors associated with a higher than average likelihood of developing mental illnesses include adverse childhood experiences, trauma and ongoing stress, family or domestic violence, and prior self-harm or suicide attempts. Early intervention services, including mentoring, are critical to support the ability of youth and young adults to develop resiliency and learn to cope effectively with adverse childhood experiences.

Project Description
Public agencies or community-based organization(s) serving at risk-youth ages 16-25 will provide intensive mentoring and support to transitional-age youth with emotional and behavioral difficulties who do not meet the criteria for specialty mental health care. The program will target very high-risk youth, including youth who are gang involved or at risk of gang involvement, have been sexually exploited as minors or transitional age youth, or have other exposures to violence, criminality, or emotional abuse that have depleted their resiliency.

Project Goal: *To reduce the risk of transitional-age youth developing serious and persistent mental illnesses which are associated with adverse childhood experiences, severe trauma or ongoing stress, family or domestic violence, and/or self-harm or suicidal thoughts.*

Project Components

Program Referrals: BHS clinicians may refer youth needing additional mentoring and support to prevent the onset of serious mental illness. Youth may also be referred from the Mobile Crisis Support Team, the Juvenile Justice Center clinical team, or the Children and Youth Services crisis team. Other referral sources may include local police departments, the County Probation Department, the City of Stockton's Ceasefire program, schools, hospitals and by self-referral utilizing a referral form.

Mentoring and Support Services: Agencies or community-based organization(s) will provide intensive mentoring and other supportive services to high-risk transitional age youth who require counseling to prevent the onset of a serious emotional disorder but do not otherwise meet the criteria for specialty mental health services. Potential evidence based approaches include:

- *Transitions to Independence (TIP):* TIP is an evidence-based practice designed to engage youth with emotional and/or behavioral difficulties in making a successful transition to adulthood. TIP programs provide case management services and supports to engage youth in activities to help resolve past traumas and achieve personal goals.

  TIP mentoring:
  - engages youth in their own futures planning process;
  - provides youth with developmentally-appropriate, non-stigmatizing, culturally-competent, and appealing services and supports; and
  - involves youth and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and successful achievement of their goals related to relevant transition domains (i.e.,

employment/career, educational opportunities, living situation, personal effectiveness/wellbeing, and community-life functioning).
For more details on the TIP model, see: http://tipstars.org

- *Gang Reduction and Intervention Programs:* The Gang Reduction and Intervention Programs (GRIP) empower youth to leave or avoid gang life. Programs works closely with local law enforcement, schools and other nonprofits to help at-risk young people develop a positive self-image and a hopeful vision for the future.

  GRIP programs are highlighted as promising strategies by the Office of Juvenile Justice and Delinquency Prevention and GRIP programs across the country are currently undergoing evaluation to demonstrate their effectiveness and reliability.

  In general GRIP programs are multi-agency collaborations that include strong community- and faith-based organizational participation and that provide interventions and support services to help gang-involved youth and their families (including younger siblings) make positive choices. Often this work requires addressing and healing past traumas. For more details see:
  http://www.ojjdp.gov/programs/ProgSummary.asp?pi=38

PEI: Prevention-Mentoring for Transition Age Youth

Cost Center(s): 6397
RU(s):

PERSONNEL COSTS

Position Description & Position #	FY19-20 Proposed Budget FTE	Base Salary	Base Benefits	MHSA Salary	MHSA Benefits
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
Total				**$0.00**	**$0.00**

	FY17-18 ACTUALS	FY18-19 YTD, 2.28.2019	FY19-20 PROPOSED BUDGET *incl S&B (above)
OPERATING COSTS	$18,804.88		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$5,617.50		
CONTRACTED SERVICE PROVIDER	$734,555.71	$394,547.04	$860,305.00
ADMINISTRATIVE / INDIRECT	$97,540.56		$129,046.00
PERSONNEL COSTS	$24,926.91		$0.00
TOTAL GROSS EXPENDITURES	**$881,445.56**	**$394,547.04**	**$989,351.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$881,445.56**	**$394,547.04**	**$989,351.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Child Abuse Prevention Council $447,473, Womens Center Youth and Family Services $412,832

PEI Project 4: Early Mental Health Services

Community Need
Research suggests that children and adolescents who have experienced trauma or abuse, and who do not receive early interventions, are at a greater risk for developing serious mental illnesses later in life. Children who have experienced trauma or abuse require tools to cope with adverse life events and interventions to reduce the long-term effects these events can cause.

Project Description
This project serves children and youth who are

(A) Engaged by the Juvenile Justice System

(B) Engaged by the Child Welfare System

Projects operate in in partnership with San Joaquin County Probation Department and San Joaquin Child Welfare Services. Services are designed to align with statewide mandates to provide early mental health support services to high-risk youth. This project also aligns with the vision and direction of the San Joaquin County Board of Supervisors.

Project Goal: *Reduce risk of Post-Traumatic Stress Disorders (PTSD) and other manifestations of trauma exposure, and improve access to treatment for those experiencing symptoms of trauma.*

Project a: Juvenile Justice Center Intervention Team

Many of the children and youth detained in the County's Juvenile Justice Center (JJC) suffer from social or emotional disturbances and early onset of mental illness. Most have been victims of abuse and trauma prior to involvement with the juvenile justice system. Left untreated, they are likely to continue the behaviors that resulted in incarceration or experience ongoing behavioral health crises.

This project provides behavioral health screening, assessment, individual and group rehabilitative interventions, and referrals to higher levels of care for youth detained in San Joaquin County's Juvenile Detention Center.

Project Activities: San Joaquin County Behavioral Health Services will provide:

> ***Screening*****:** As part of booking and detention procedures, staff of San Joaquin County's JJC conduct a behavioral health screening using the validated, evidence-based Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2). For more information about MAYSI-2 see: http://www.nysap.us/MAYSI2.html
>
> ***Assessment*****:** Youth who are on psychotropic medications or whose MAYSI-2 score indicate high to moderate behavioral health risk receive an evaluation by BHS staff within 24 hours. During this evaluation, a Mental Status Exam is done, risk factors are assessed, services are offered, and accessing mental health services while at JJC is explained. Youth with low to moderate indicators are evaluated within five days.

Crisis intervention: Youth who disclose suicidal ideation or threaten suicide during booking or at any time during their detention are immediately referred to BHS clinicians for evaluation.

Coordination of services: JJC clinicians inform the outpatient coordinator when a youth with an open behavioral health case is booked at the JJC. The JJC mental health service provider collaborates with the outpatient coordinator to continue treatment within BHS or a range of community based providers.

Behavioral health interventions: Detained youth receive behavioral health interventions in accordance with their clinical assessment. Interventions include medication management and individual and/or group therapy, and case management. The development of the client treatment plan and case management activities is conducted in collaboration with the youth, parents/caregivers, probation officers and social workers.

Release planning: BHS staff work with youth, family members, probation and child welfare workers to ensure that services and supports are not interrupted upon release or transfer from the JCC.

Supportive Program Milieu: Utilize emerging best practices to promote trauma informed approaches and create organization partnerships that are responsive to the behavioral health needs of youth in custody.

Project b: Coping and Resiliency Education Services (CARES)

Children and youth involved in the child welfare system are more likely to have been exposed to traumatic incidents, and those who are placed in foster care have undoubtedly experienced traumatic situations based on the fact that they have been separated from their family, and by the circumstances that led to their removal. Recognizing trauma and the effects of trauma among child welfare-involved children, minimizing additional trauma, and providing timely interventions to address trauma symptoms are core responsibilities of public agencies.

Behavioral Health and Child Welfare Departments should work together to ensure that children and youth involved in the child welfare system receive comprehensive trauma screening and timely referrals to the most appropriate level of care, and depending on care needs, short-term behavioral interventions or longer-term treatments. This continuum of care should be offered within children's homes or in other community-based settings.

Furthermore, in alignment with AB 403, Behavioral Health and Child Welfare Systems should work collaboratively to ensure that youth in foster care have their day-to-day physical, mental and emotional needs met. Towards this end public agencies should offer training and support to foster families (now referred to as resource families) to better prepare them to care for children who've experienced traumatic situations, and whose experiences may result in trauma-related mental health symptoms.

This project provides screening, assessment, individual and group rehabilitative interventions, and referrals to higher levels of care for children that have formal or informal involvement with child welfare or the juvenile justice system. This project is responsive to California's Welfare Reform Act (AB 403) and creates an Integrated Core Practice Model to deliver timely, effective, and collaborative services to children/youth and their families.

Project Activities: San Joaquin County Behavioral Health Services will:

- Develop formal collaboration with San Joaquin's Child Welfare Services Department to 1) identify Child Welfare-involved children and youth who are at risk for trauma-related illnesses; and 2) develop and implement strategies to meet their ongoing needs.
- Screen Child Welfare-involved children and youth for trauma and trauma-related symptoms.
- Refer children and youth to appropriate levels of care, including comprehensive behavioral health assessment, as appropriate.
- Provide short-term problem solving, safety planning, coping and resiliency skill-building to children who do not meet medical necessity for Specialty Mental Health Services.
- Provide ongoing services and supports for all children and youth who meet prevention and early intervention criteria as they transition from Mary Graham or other temporary placements to permanent homes.
- Provide trauma-informed support and training to resource families who are linked with Foster Family Agencies.
- Provide early intervention services for children/youth that are screened out of Pathways to Wellbeing due to a decreased level of acuity.

Project Component 1: Timely Trauma-Informed Screening

Children and youth ages, 6-17, who do not meet medical necessity for specialty mental health services, but who are referred by Child Welfare, or other child serving agencies, will be screened by BHS Clinicians and Mental Health Specialists using the Traumatic Stress Symptoms Module of Child and Adult Needs and Strengths Assessment (CANSA). The CANSA is a locally-developed, validated assessment, treatment planning, and evaluation tool adapted from Praed Foundation's Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths (ANSA) instruments to serve San Joaquin County's behavioral health consumers across the age spectrum. A copy of the entire CANSA instrument may be found at www.praedfoundation.org.

Based on screening results and the child or youth's age, he or she will be linked to a variety of trauma-informed interventions. Screenings may be provided off-hour and on weekends in home-based and community settings, including Mary Graham Children's Center.

Component 2: Trauma-Informed Interventions

Once screened, children and youth will be linked to supportive short-term evidence-based interventions to address previous traumas and sustain them through difficult transitions. Interventions will be provided at clinic, community-and or home-based locations, and may include the following:

> *PRAXES (Parents Reach Achieve and eXcel through Empowerment Strategies) Empowerment for Families*—Training and education by behavioral health providers to help resource families and other caregivers cope with expectations; develop stress management techniques; reintegrate children and youth with their families; and handle child's trauma. For more information see http://www.praxesmodel.com/. Trained staff will provide one on one and group support and education.
>
> *CRAXES (Children Reach Achieve and eXcel through Empowerment Strategies) —12 session program for children ages 5-11. This curriculum mirrors the PRAXES components but is interactive and configured for younger children.*

YRAXES (Youth Reach Achieve and eXcel through Empowerment Strategies) —12 session program for youth ages 12-18. This curriculum mirrors the PRAXES components but is interactive and configured for adolescents.

Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems – MATCH-ADTC is individualized Clinical therapy for children, ages 6-12, using a collection of therapeutic components to use in day-to-day practice. The components include cognitive behavioral therapy, parent training, coping skills, problem solving and safety planning. The modules are designed to be delivered in an order guided by clinical flowcharts based on primary area of concern (e.g., trauma-related issues). For more information, see http://nrepp.samhsa.gov/ProgramProfile.aspx?id=64

Component 3: Child Family Team

A Child Family Team (CFT) is a group of individuals who are engaged in a variety of processes to identify strengths and needs of the child or youth and his or her family, to help achieve positive outcomes for safety permanency, and well-being. For children and youth engaged into ICPM services, BHS provides CFT facilitators that coordinate the therapeutic, medical and rehabilitative care that is directed through the CFT process.

Component 4: Resource Family Supports

BHS will offer Resource families, including kinship families, training in the causes and effects of adverse childhood experiences such has child abuse and neglect, strategies for dealing with trauma reactions; and strategies for self-care. BHS will use an evidence-based curriculum such as:

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents – This is a PowerPoint-based designed to be taught by mental health professionals and a foster parent co-facilitator. The curriculum includes case studies of representative foster children, ages 8 months – 15 years, and addresses secondary traumatic stress in caregivers. The training includes a Participant Handbook with extended resources on Trauma 101; Understanding Trauma's Effects; Building a Safe Place; Dealing with Feelings and Behaviors; Connections and Healing; Becoming an Advocate; and Taking Care of Yourself. For more information, see http://www.nctsn.org/products/caring-for-children-who-have-experienced-trauma

BHS and CWS continue to review best practices for supporting resource families. Additional support strategies may be incorporated as new promising practices are identified statewide.

Project Component 5: Collaborative Meetings

San Joaquin County BHS will initiate quarterly meetings with Children's Services. Meetings will involve PEI program staff and Child Welfare staff responsible for program development and referrals. Meeting objectives will include the ongoing development of seamless referral processes to support timely trauma screenings and interventions. The collaborative will explore community needs, service gaps, and effective strategies for addressing childhood and adolescent trauma within the County.

PEI: EI for C&Y-Early Mental Health Services

Cost Center(s): 6391,6394
RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	1.25			$138,606.00	$90,194.00
Mental Health Clinician I	5.00			$344,445.00	$241,750.00
Mental Health Clinician III	2.00			$157,414.00	$105,025.00
Mental Health Outreach Worker	4.00			$159,204.00	$101,483.00
Mental Health Specialist II	7.00			$349,637.00	$229,517.00
Psychiatric Technician	1.00			$47,047.00	$23,604.00
Psychiatrist	0.22			$64,920.00	$11,356.00
Office Assistant Specialist	0.50			$22,891.00	$18,890.00
Sr. Office Assistant	2.00			$78,645.00	$55,114.00
Sr. Psychiatric Technician	1.00			$57,146.00	$28,539.00
				$0.00	$0.00
				$0.00	$0.00
				$1,419,955.00	**$905,472.00**
Total	23.97			**$2,325,427.00**	
Overtime				$1,000.00	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$133,115.02	$17,274.82	$57,384.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$1,739.21		$13,000.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$5,617.50		
CONTRACTED SERVICE PROVIDER	$567,466.40		
ADMINISTRATIVE / INDIRECT	$348,192.43	$200,917.29	$357,572.00
PERSONNEL COSTS	$1,781,593.87	$1,322,173.75	$2,326,427.00
TOTAL GROSS EXPENDITURES	**$2,837,724.43**	**$1,540,365.86**	**$2,754,383.00**
Offsetting Revenue			
Medi-Cal	$514,497.00		$850,703.00
Realignment	$0.00		$9,621.00
Other	$13,306.00		$5,500.00
Total	**$527,803.00**	**$0.00**	**$865,824.00**
TOTAL NET EXPENDITURES	**$2,309,921.43**	**$1,540,365.86**	**$1,888,559.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support the PEI Program.

Brief description of items included in Non-Recurring Costs:

Small furniture and equipment $5,600 Computer equipment $7,400

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

PEI Project 5: School-based Interventions

Community Need
Research suggests that children and adolescents who have experienced trauma or abuse, and who do not receive early interventions, are at a greater risk for developing serious mental illnesses later in life. Children who have experienced trauma or abuse require tools to cope with adverse life events and interventions to reduce the long-term effects these events can cause.

Project Description
This project provides funding for brief mental health counseling and early intervention services for children and youth with emerging mental health concerns in order to promote recovery, improve functional outcomes, reduce suffering, and avert potential negative outcomes associated with untreated mental health concerns including suicide, incarceration, school failure or drop-out, etc.

This project will operate in schools that provide public education services (including public charter schools) to children and youth who may be at a greater than average risk of developing a potentially serious mental illness. Examples of risk factors include but are not limited, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, etc.

Funding will be allocated through rate based contracts to qualified Organizational Providers that agree to provide desired on-site school based interventions and other support services. Contracts will be developed through a public procurement process to identify qualified vendors. BHS intends to contract with multiple qualified vendors. School Districts will be able to request school-based mental health early intervention services from BHS approved providers for schools that meet criteria through an application process.

Public schools in San Joaquin County that are eligible for program activities must meet one or more of the following criteria:

High School Criteria (9-12):

- At least 60% of enrolled students are eligible for free meals; or
- At least 65% of enrolled students are eligible for free or reduced price meals (FRPM)

Elementary / Middle School Criteria (K-8):

- At least 70% of enrolled students are eligible for free meals; or
- At least 75% of enrolled students are eligible for free or reduced price meals (FRPM)

Exceptions: A school district may contact BHS to request school-based intervention services following a traumatic event that affects the majority of students in the school.

Implementation:

Step 1: Establish a List of Qualified Providers

BHS shall identify potential Organizational Providers through a request for qualifications process. Organizational Providers must have a demonstrated capacity to provide mental health counseling and early intervention services to children and youth on school campuses.

Minimum qualifications: Program partners must demonstrate:

- Possession of certification as a Short-Doyle Medi-Cal Organizational Provider.
- Experience providing clinical treatment services to children and youth.
- Experience providing social, emotional, and rehabilitative group services to children and youth.
- Demonstrated training and capacity to provide evidence-based treatment interventions, including cognitive behavioral and trauma-informed services.
- Experience providing services within a school milieu.
- Capacity to work in partnership with schools to provide services around an academic calendar.
- A client management and billing system that meets CA Medi-Cal requirements.
- Adequate supervision plan and ratios for any unlicensed clinical staff.
- Capacity to assign dedicated "Clinicians on Campus" to work with partnering schools for a minimum of two days a week, for periods of at least six hours per on-site day.
- Capacity to provide on-site school-based service to at least ten different schools.

Step 2: District Request for Services

BHS shall notify school districts of availability of funding. Schools districts with schools that meet the eligibility requirements will be asked to submit a request for services form. The request for services form must be signed by the Superintendent and the Principal for each school for which services will be provided. Principals must provide the following:

- Partner preferences: a ranked listing of the preferred program partner.
- Justification for clinician hours in excess of twelve (12) per week. Justification may include large campus size (more than 600 students); high rates of suspension or expulsions; other community justification associated with experiences of severe trauma.
- Dedicated desk space for clinician during their time on campus.
- Dedicated space for confidential one-on-one or group activities to be conducted.
- A preferred work schedule for clinicians on campus.
- A dedicated campus point of contact.

This program will have limited capacity at start-up. Program capacity will be restricted by clinician availability and funding resources. BHS intends to ensure that multiple school districts, throughout the County, can participate in the program. However, due to limited resources, access to the program services will be prioritized for the schools with the highest rated need and best fit between school and Organizational Provider capacity. Superintendents must provide the following:

- Rank order of the schools within the district for which services should be provided upon availability of clinicians and funding resources.
- Partner preferences: a ranked listing of the preferred program partner.
- Evidence that the School District has adopted policies to promote a safe and supportive school climate. Examples would include resolutions and/or polices promoting evidence based practices, including but not limited to, restorative justice, positive behavioral interventions, etc.
- Agreement to enter into a memorandum of understanding between BHS and the District. The partnership agreement will include requirements for data collection, quarterly reports, and participation in evaluation activities. Participation in a program evaluation is required for receipt of PEI funds.
- Agreement to assign a project coordinator to meet with BHS on a regular basis.

Project Goal: *Reduce risk of Post-Traumatic Stress Disorders (PTSD) and other manifestations of trauma exposure, and improve access to treatment for those experiencing symptoms of trauma.*

Project Components:

Qualified Organizational Providers shall assign dedicated clinicians to work with participating schools. Program duties and responsibilities will include:

A. On-site School-Based Services

Dedicated clinicians are participants of a school-team that helps every student achieve their best educational potential. The purpose of the Clinician on Campus is to provide mental health interventions for children and youth who are determined to have mental health concerns that cannot be address through the school's usual behavior management policies or through an individual education plan.

Clinical staff will provide:

1. ***Therapeutic or Rehabilitative Groups:*** Facilitate age-appropriate cognitive behavioral or other therapeutic groups to help children and youth practice impulse control, emotional regulation, positive & affirming relationships with peers and adults, etc. Group activities will follow an approved evidence based curriculum. Groups should be offered on campus and at times appropriate for school-age children, such as during lunch or after school, in order to minimize loss of classroom time.

2. ***Short-term Interventions for Children***: Provide short-term, evidence-based, trauma interventions for children believed to be suffering from the effects of traumatic incidents. These interventions will include assessments, case management, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), and linkages to alternate or additional services as needed.

    a. **Assessment:** Assess and evaluate the behavioral health needs of students referred by school-site personnel. The assessment will be conducted by a clinician and will include a diagnostic impression, mental status exam, and developmental history. The assessment process will also include the development of a Client Plan with the student and/or the legal guardian and/or primary caregiver.

    b. **Case Management:** Targeted case management services to help children reach their mental health goals, by providing education on mental health issues, and linking children to services such as more intensive services on campus, or referral to more appropriate services within the community or to BHS.

    c. **Mental Health Services:** As clinically appropriate, services may include: Individual counseling (with or without family present), collateral contacts, individual rehabilitative services, and group rehabilitative services.

    d. **Referrals:** All children screened will be assessed to determine if they are appropriate for the short-term intervention or whether they should be immediately referred to more specialized services. All children receiving short-term interventions will be monitored to

determine if, during the services or at completion, they should be referred to more intensive services.

3. ***Student Support Teams**:* Schools and parents may jointly decide to form a student support team to address the needs of a student. As appropriate, on-site clinicians will participate in student support team meetings.

B. Program Operations and Supervision

- Clinical and operational supervision of all program staff; including tracking of hours and activities conducted through this project.
- Convene meetings of the clinical team at least twice a month to share lessons learned and discuss strategies for improving services at school sites.
- Documentation and billing to Medi-Cal of reimbursable services for children and youth.
- Participation in quarterly services meetings with BHS and School Districts' project coordinators.
- Submission of quarterly reports, participation in ongoing data collection, and compliance with all evaluation and contract monitoring activities

PEI: EI for C&Y-School Based Interventions

Cost Center(s): 6392
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
Total				**$0.00**	**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00		$2,914,259.00
ADMINISTRATIVE / INDIRECT	$0.00		$437,139.00
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$3,351,398.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$3,351,398.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP 18-19, Contract to be awarded in 19-20 $2,914,529

PEI Project 6: Early Interventions to Treat Psychosis

Community Need: Research suggests that it is possible to prevent the acute onset of major psychotic disorders through a systematic approach to early identification and treatment. Identifying and responding appropriately to the condition early can prevent disability and may prevent the onset of the acute stage of illness. Psychotic disorders rarely emerge suddenly. Most often, the symptoms evolve and become gradually worse over a period of months or even years. Early symptoms of cognitive and sensory changes often go undiagnosed which can cause significant disability before the illness becomes acute and is diagnosed.

Project Description: The Early Interventions to Treat Psychosis (EITP) program to provide an integrated set of promising practices that research has indicated will slow the progression of psychosis, early in its onset. The EITP program will offer a combination of outreach, engagement, and evidenced-based treatments and supports, delivered to individuals throughout San Joaquin County, age 14-34, who have experienced their first full psychotic episode in the past two years or who are showing prodromal symptoms of psychosis.

Promising models include, but are not limited to:

1. Early Assessment and Support Alliance (EASA)
   Refer to: http://www.easacommunity.org/

2. Portland Identification and Early Referral Program (PIER)
   Refer to: http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/10/early-detection-and-intervention-for-the-prevention-of-psychosis.html

Project Goal: *To identify and provide treatment to individuals who have experienced their first full psychotic episode in the past two years or who are showing prodromal symptoms of psychosis in order to prevent disability and the onset of the acute stage of illness.*

Project Components

Program Referrals - Referrals to the EITP can come by a variety of resources, however, approval for program enrollment will be the responsibility of BHS.

Outreach and Engagement - Trained clinicians and peers will provide presentations to community agencies and organizations, service providers, and community members about early identification of schizophrenia and the services available to promote remission and recovery. Assessments will be provided in peoples' homes and in locations of their choosing. Active engagement efforts will aim to discourage individuals from dropping services once they are enrolled.

Assessment and Diagnosis – Trained clinicians will conduct a strength-based, recovery-oriented assessment using formal clinical assessment tools. There will be a follow up conducted every 12 months to determine exit readiness using an evidenced-based or promising practice tool or method.

Cognitive Behavioral Therapy (CBT) – CBT has been demonstrated in numerous research studies to be effective for depression, anxiety disorders, substance abuse, bipolar disorder, and schizophrenia (as an adjunct to medication), and for a variety of medical problems with psychological components. Cognitive Behavioral Therapists use a wide variety of techniques to help patients change their cognitions, behavior, mood, and physiology. Techniques may be cognitive, behavioral,

environmental, biological, supportive, interpersonal, or experimental. Cognitive-behavioral techniques include psycho-education, relaxation, social problem solving and cognitive restructuring.

Education and Support Groups – Provide rehabilitation and support groups, based on evidence based or promising practices, for consumers and family members. These groups will be designed to inform consumers and family members about mental illness, educate on how to access services needed, techniques of developing coping skills, and creating a social support system.

Medication Management: Provide medication management services to educate consumers regarding their psychiatric medications, symptoms, side effects and individualizing dosage schedules. Medications must be deemed effective and follow the current accepted standards of practice in the psychiatric community.

Individualized Support and Case Management: Case managers will work with clients and family members to address depression, substance abuse, family issues, and other challenges that impede recovery. Case managers will work to ensure that clients find and keep meaningful work, education, and permanent housing.

PEI: EI for C&Y-Early Interventions to Treat Psychosis

Cost Center(s): 6398
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total					**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$600,000.00	$394,878.09	$996,771.00
ADMINISTRATIVE / INDIRECT	$0.00	$59,231.71	$149,516.00
PERSONNEL COSTS	$0.00	$771.69	$0.00
TOTAL GROSS EXPENDITURES	**$600,000.00**	**$454,881.49**	**$1,146,287.00**
Offsetting Revenue			
Medi-Cal	$506,503.00		$682,538.00
Realignment	$0.00		
Other	$5,441.00		$100.00
Total	**$511,944.00**	**$0.00**	**$682,638.00**
TOTAL NET EXPENDITURES	**$88,056.00**	**$454,881.49**	**$463,649.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Telecare $996,771

PEI Project 7: Community Trauma Services for Adults

Community Need: Adults who have experienced (or are currently experiencing) childhood trauma, sexual trauma, domestic violence, community violence, traumatic loss, racism-related trauma, sexual-identity related trauma, or military trauma are at heightened risk for post-traumatic stress reactions, severe anxiety disorders, depression, and/or co-occurring trauma and substance use disorders.

Project Description: PEI funding will be awarded to one or more community partners with expertise in providing licensed, clinical mental health treatment services to individuals with mild/moderate PTSD and associated stress disorders. Partner organizations must also be able to demonstrate a capacity to provide culturally competent services that address the needs of unserved and underserved populations, especially those from disadvantaged communities with compounded negative social determinants of health.

The target populations for this project are individuals that are especially vulnerable to the adverse consequences of mental health challenges. Vulnerable populations include, but are not limited to immigrants, refugees, uninsured adults, Veterans, LGBTQ individuals, victims of intentional physical violence (gun-shot wounds, assaults, and stab wounds), victims of human trafficking or at risk of human trafficking, and those with Limited English Proficiency (LEP).

Additional priority populations are:

- Victims of intentional trauma (gun-shot wounds, assaults, and stabbings) identified by the San Joaquin General Hospital's *Victim Services Coordination Team*

- Victims of human trafficking identified by the Family Justice Center.

Organizations will provide trauma informed care and create trauma informed cultures and organizational practices.

Services will be available 24 hours a day, seven days a week to provide urgent mental health care to victims of intentional trauma at San Joaquin General Hospital (SJGH). Services will also be provided to family members of victims as needed. Hospital response will be within 60 minutes of initial referral from SJGH. Service provider(s) shall also participate in the SJGH *Victim Services Coordination Team*.

Services will be offered to victims of human trafficking or those at risk of human trafficking at the Family Justice Center. The services provider will coordinate services with the FJC.

Program Goal: *Address and promote recovery amongst adults with emerging PTSD and/or associated stress disorders to improve functioning and reduce negative outcomes associated with untreated mental health conditions.*

Project Components*:* At a minimum, the following activities will be conducted by all projects within this program.

Mental Health Services will include:

a. **Screening and Assessment:** Use of a validated screening or assessment tool to screen for trauma, anxiety, depression, or other behavioral health concerns. Examples of validated tools include, but are not limited to, the PHQ-9, PTSD Checklist, Life Event Checklist, Abbreviated PCL-L, Trauma Symptom Checklist -40, Los Angeles Symptom Checklist (Adult Version), etc. Screening and assessment tools must be approved by BHS prior to beginning services.

b. **Case Plan:** Each individual shall have an individualized case plan, based upon the findings of the assessment.

c. **Benefit Assistance:** Each individual shall meet with a benefit assistance specialist to determine eligibility for health care coverage and or other benefits and receive application assistance. Benefit assistance should also include ongoing consumer education on the importance of maintaining coverage and address misconceptions about coverage and confidentiality.

d. **Case Management:** Targeted case management services to help adults and older adults reach their mental health goals, by providing education on mental health issues and linking individuals to available community services and supports, including primary health care.

e. **Rehabilitative Services:** As clinically appropriate, services may include skill building groups and activities or other group rehabilitative services provided by trained (bachelor's level) social workers, nurses, or other health professionals.

f. **Short-term Clinical Treatments** (**Early Interventions):** Individual or group counseling using one or more trauma-responsive evidence-based practices for which a substantial body of research evidence exists. Approaches are implemented by trained (master's level) clinicians or mental health professionals. Examples of evidence based practices include, but are not limited to:

    i. Seeking Safety
    ii. Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
    iii. Trauma Affect Regulation: Guide for Education & Therapy (TARGET)

    A further listing of evidence based programs and practices may be found at:
    - National Registry of Evidence Based Programs and Practices
    - California Evidence Based Clearinghouse

g. **Referrals:** All adults screened will be assessed to determine if they are appropriate for the short-term intervention or whether they should be immediately referred to more specialized services.

h. **Staffing:** At least one of the staff dedicated to each project will be a licensed mental health clinician to supervise the work of other clinical staff.

PEI: Community Trauma Services for Adults

Cost Center(s): 6392
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
Total				**$0.00**	**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00	$0.00	$1,200,000.00
ADMINISTRATIVE / INDIRECT	$0.00		$180,000.00
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$1,380,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$1,380,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP 19-20 $1,200,000

PEI Project 8: Recovery Services for Victims of Human Trafficking

Community Need
Human trafficking is a criminal industry plaguing California counties. San Joaquin County recognizes that the Central Valley has a large concentration of sex trafficking, as well as other forms of human trafficking. BHS participates in a county wide Human Trafficking Taskforce with the goal of identifying victims, providing outreach, linkage to community resources, and mental health treatment.

Project Description
The San Joaquin County Family Justice Center strives to provide a one-stop location where victims and families can obtain resources to assist them with getting out of "the life". Victims can receive many referrals and resources but often do not understand the value of each resource. Additionally, victims often suffer from low self-esteem; limited access to natural supports; and trauma related symptomology. This often limits the victims' ability to access available resources in a way that will help them meet their goals and find recovery.

BHS will provide funding to a community based organization providing counseling and case management services for San Joaquin County's Commercial and Sexually Exploited Children Prevention and Intervention Project. BHS funding will expand the target population to include all victims of human trafficking regardless of age or gender.

Project Goal: *To identify and provide treatment to individuals who victims of human trafficking or other exploitation that are showing symptoms of post-traumatic stress disorder, recovering from a cycle of abuse and intimidation, and overcoming unhealthy attachments.*

Project Components

1. **Screening and Engagement**
   Referrals for mental health screening and program engagement will occur through the San Joaquin County Family Justice Center and may be triggered by a first responder (outreach worker or law enforcement) contact. Potential program participants will be screened for behavioral health concerns, including depression, substance use disorders, trauma exposure, and suicide risk. Individuals with serious mental health concerns will be referred to BHS for further assessment and/or crisis intervention.

2. **Case Management and Resource Navigators**
   Program participants will be assigned a resource navigator to help them learn about the resources and opportunities that are available to help victims recover and assist with getting timely and appropriate entry into services, including substance use disorder treatment services. Navigators also provide case management support and may help victims obtain a valid ID, get to appointments, or complete benefits applications or other paperwork.

3. **Clinical Interventions and Support Services**
   All program participants will be eligible to participate in therapeutic group services that will be facilitated by mental health specialists or clinicians. Therapeutic groups may include, but are not limited to:

   - **Education and Support Groups –** Provide rehabilitation and support groups, including multi-family groups, based on evidence based or promising practices, for victims and/or family

members. These groups will be designed to inform victims and family members about human trafficking, educate them on how to access services, and providing techniques for developing coping skills and creating a social support system.

- **Trauma Focused Coping Skills** Provide coping skills therapy to help people attain safety from trauma and regulate their emotions in the context of day-to-day stressors that are faced during the recovery process. Coping skills groups provide brief and targeted interventions to help individuals put knowledge, strategies, and skills into practice. Many coping skills approaches utilize a cognitive behavioral approach. See for example, Seeking Safety for a trauma informed approach to overcoming substance use.
  See: http://www.treatment-innovations.org/
- **Additional Interventions –** Additional interventions may be selected based on the needs of clients, implementation experiences, and emerging best practice research, in consultation with BHS. Promising practices include, but are not limited to:
  - Ending the Game: a **"coercion resiliency"** curriculum that reduces feelings of attachment to traffickers and/or a lifestyle characterized by commercial sexual exploitation, thereby reducing the rate of recidivism among sex trafficking survivors. See http://endingthegame.com/etg/

4. **Supportive Program Milieu**
   Provide training to program staff on creating a safe, trauma informed environment. Utilize emerging best practices to educate and inform program partners on the incidence and consequences of commercial sexual exploitation and create organization partnerships that are sensitive and responsive to the needs of program participants. See for example, the Sanctuary Model for creating trauma informed organizational cultures at: http://www.sanctuaryweb.com/.

Project will be implemented in collaboration with activities offered through the San Joaquin County Family Justice Center operated by the Office of the District Attorney.

PEI: EI for Adults-Recovery Services for Victims of Human Trafficking

Cost Center(s): 6392
RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Mental Health Clinician I	1.00			$66,019.00	$46,313.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$66,019.00	**$46,313.00**
Total				**$112,332.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00	$4,615.40	
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$152,902.60	$274,587.85	$600,000.00
ADMINISTRATIVE / INDIRECT	$42,857.60		$106,850.00
PERSONNEL COSTS	$98,573.40	$3,000.92	$112,332.00
TOTAL GROSS EXPENDITURES	**$294,333.60**	**$282,204.17**	**$819,182.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$294,333.60**	**$282,204.17**	**$819,182.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Womens Center Youth and Family Services $600,000

PEI Project 9: Recovery Services for Nonviolent Offenders

Community Need: A small population of nonviolent offenders with emerging behavioral health concerns is having a significant impact on the community. These repeat offenders are having difficulty stabilizing in recovery and are receiving inappropriate treatment interventions in jail. Better behavioral health engagement and early interventions are needed to support recovery efforts and divert individuals with behavioral health concerns away from subsequent contact with the criminal justice system.

Project Description: BHS will work with San Joaquin County Courts, District Attorney, and local law enforcement agencies to provide targeted outreach and engagement, screening and assessment, and linkage to appropriate services and supports. Brief interventions will be offered to individuals identified with emerging mental health concerns such as PTSD or associated disorders. A significant portion of the target population is assumed to be homeless and/or have co-occurring disorders.

Project Goal: Engage individuals with behavioral health concerns that are repeat non-serious, nonviolent offenders and provide recovery and rehabilitation services to increase functioning in order to reduce negative outcomes associated with untreated mental health concerns such as arrest, incarceration, homelessness, and prolonged suffering.

Project Components:

Project 1: Law Enforcement Assisted Diversion (LEAD)

The Law Enforcement Assisted Diversion is a program of the Stockton Police Department's Special Patrol Unit. BHS staff work with LEAD Patrol Officers to engage individuals identified as non-serious, non-violent law violators with likely mental health concerns. Activities conducted by the team may include, but are not limited to street outreach, communication and coordination with law enforcement partners, engagement and screening for behavioral health concerns, transport to clinic or other location for psychosocial assessment, ongoing case management, navigation support to transition into treatment services, and family engagement / reunification opportunities.

Project 2: Offender Assessment Services

Provide screenings and assessment for individuals released from incarceration to determine if further mental health and/or co-occurring substance use disorder treatment is warranted. May include linkages to mental health, substance use disorder treatment, and/or other community services.

PEI: EI for Adults-Recovery Services for Nonviolent Offenders

Cost Center(s): 6306
RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Mental Health Outreach Worker	3.50			$121,030.00	$65,262.00
Mental Health Specialist II	3.50			$161,801.00	$85,113.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$282,831.00	**$150,375.00**
Total	7.00			**$433,206.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		$4,500.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		$35,000.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$0.00		$65,656.00
PERSONNEL COSTS	$0.00		$433,206.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$538,362.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$538,362.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support the PEI Program.

Brief description of items included in Non-Recurring Costs:

One 4 door sedan for consumer outreach and transportation $35,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

PEI Project 10: Forensic Access and Engagement

Community Need:

Repeat offenders with behavioral health concerns may be charged and remanded to one of San Joaquin County Superior Court's Collaborative Court Programs designed for individuals with behavioral health or other special concerns. BHS currently provides mental health treatment interventions for all individuals served by the collaborative court system with serious mental illnesses through its Forensic Full Service Partnership Program. Through PEI funding, behavioral health services may also be provided to eligible collaborative court participants with mild/moderate or emerging mental health concerns.

Project Description: BHS will provide funding to a community based organization to work with individuals with mild-moderate mental health concerns that, left untreated are resulting in repeat incarcerations, prolonged suffering, and risk of homelessness. This project is a collaborative endeavor between BHS, San Joaquin County Probation Department, and the Superior Court. Activities may include but are not limited to screening and assessment, individualized case management, rehabilitative groups and activities, and navigation support to engage and maintain in needed treatment services, including substance use treatment services.

Project Components:

- Outreach: Meet with clients while they are custody or remanded to court to establish rapport, complete a client assessment, and develop a case plan.
- Assessment: Develop an assessment of client needs and strengths. Include both long term and short term mental health needs. Include assessment of alcohol and other drugs and develop a client treatment plan for mental health and substance use treatment services.
- Placement and Stabilization Planning: Work with clients to review housing options. For some clients this may include developing a plan to reunify them with their families.
- Continuing Care Planning: Work with client and or family members to develop a plan for continued engagement in treatment. This may include obtaining assistance with needed medications or arranging transportation to appointments.
- Client Engagement: Provide frequent, low demand contacts with clients where they live or are most comfortable.
- Case Management: Assist clients in accessing primary and behavioral health care services, peer-based services, and financial, educational, prevocational, rehabilitative or other community based services and supports needed by clients to meet their personal goals.
- Meaningful Activities: Provide support and linkages for clients to enroll in educational of vocational programs (including pre-vocational readiness to work programs) and /or community service activities.

PEI: EI for Adults-Forensic Access & Engagement

Cost Center(s): 6392
RU(s):

PERSONNEL COSTS

Position Description & Position #	FY19-20 Proposed Budget FTE	Base Salary	Base Benefits	MHSA Salary	MHSA Benefits
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
Total				**$0.00**	**$0.00**

	FY17-18 ACTUALS	FY18-19 YTD, 2.28.2019	FY19-20 PROPOSED BUDGET *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00		$600,000.00
ADMINISTRATIVE / INDIRECT	$0.00		$90,000.00
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$690,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$690,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP 19-20, $600,000

PEI Project 11: Whole Person Care Project

Community Need: Individuals with mental illnesses are at high risk of becoming homeless. Individuals who are homeless are at greater risk of being unserved or underserved by mental health services. In San Joaquin County approximately 30% of homeless individuals are believed to have some level of mental health concern. Targeted efforts are needed to help homeless individuals, and those at risk of homelessness upon discharge from an institution, access services including behavioral health treatment.

Project Description: This project provides match funding for San Joaquin County's Whole Person Care Pilot Project, approved by DHCS in 2016. Match funding will be allocated (at a minimum) for the five years of the project.

The purpose of San Joaquin County's Whole Person Care pilot project is to test interventions and create a care management infrastructure to better support individuals who are at high risk of untreated mental illness *and* are high utilizers of health care services. Program services target adult Medi-Cal beneficiaries who over-utilize emergency department services, have a mental health and/or substance use disorder, or are currently, or are homeless or at risk for homelessness upon discharge from an institution.

Project Components: Whole Person Care, Outreach, Engagement, and Linkage to Treatment

- *Homeless Outreach Team* provides outreach and engagement to individuals experiencing homelessness in San Joaquin County. Chronic and persistent homelessness is correlated to serious mental illness. An existing homeless outreach team will be expanded through MHSA expenditures. Outreach team members will conduct outreach and engagement to enroll individuals into program services and offer non- Medi-Cal reimbursable services such as transportation, meals, information and other supports to stabilize individuals and build rapport.
    - Conduct outreach and engagement to enroll individuals into program services.
    - Offer non- Medi-Cal reimbursable services such as transportation, meals, information and other supports to stabilize individuals and build rapport.
    - Conduct outreach, engagement, and follow-up with homeless individuals referred by the Mobile Crisis Support Team for further mental health treatment interventions.

- *MHSA Integration Team* will provide integrated care coordination and case management across county agencies, health plans, providers, and other entities. Care coordination will be expanded through MHSA expenditures to ensure intensive and appropriate care coordination for designated project target populations.
    - Provide integrated care coordination and case management across county agencies, health plans, providers, and other entities.
    - Provide services where individuals are located and best served, whether within the community, shelter, or hospital setting.
    - Conduct, research, data collection, and analysis to ensure project activities are effective and improving outcomes for consumers.

PEI: Access & Linkage-Whole Person Care Project

Cost Center(s): 6387
RU(s):

PERSONNEL COSTS

		FY19-20 Proposed Budget			
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Chief Mental Health Clinician	0.50			$55,625.00	$27,292.00
Mental Health Clinician I	1.00			$76,066.00	$51,938.00
Mental Health Outreach Worker	1.00			$33,842.00	$30,591.00
Mental Health Specialist II	2.00			$94,755.00	$54,008.00
Office Assistant Specialist	1.00			$45,115.00	$29,738.00
Substance Abuse Counselor II	3.00			$138,091.00	$111,575.00
				$0.00	$0.00
				$443,494.00	**$305,142.00**
Total	8.50			**$748,636.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$62,153.83	$11,747.41	$104,100.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$1,190.72		$41,400.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$49,156.48	($61,623.83)	$35,004.00
PERSONNEL COSTS	$465,992.78	$297,710.06	$748,636.00
TOTAL GROSS EXPENDITURES	**$578,493.81**	**$247,833.64**	**$929,140.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$77,494.00		$511,127.00
Total	**$77,494.00**	**$0.00**	**$511,127.00**
TOTAL NET EXPENDITURES	**$500,999.81**	**$247,833.64**	**$418,013.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

prised of general operating service and supply costs required to support the PEI Program, Including Special Needs for outreaching to clients $50,000

Brief description of items included in Non-Recurring Costs:

One 4 door sedan for outreach and client transport $35,000 Small furniture and equipment $6,000 Computer supplies $400

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

PEI Project 12: Increasing Recognition of Mental Illnesses

Community Need
Mental illnesses are common, and failure to provide appropriate and timely treatment can have serious and detrimental consequences for individuals, families, and communities. Community trainings to increase the recognition of early signs of mental illnesses and to effectively respond and link individuals to services are needed to improve timely access to mental health services for all individuals, and especially for individuals and/or families from underserved populations.

Project Description
Trainings will reach out to community leaders, service providers, college instructors, religious or spiritual leaders, and consumers and family members to provide information on how to increase recognition and respond effectively to the signs and symptoms of potentially severe and disabling mental illness. Trainings are also offered to consumers, parents/guardians, and other family members in order to provide information about mental health conditions that encourage individuals and families to overcome negative attitudes or perceptions about mental illnesses, recent diagnosis, and/or help seeking behavior.

Project Goal: *To develop community members as effective partners in identifying individuals in need of treatment interventions early in the emergence of a mental illness and preventing the escalation of mental health crises and promoting behavioral health recovery.*

Project Components

Trained instructors will provide evidence-based classes to service providers, consumers and family members. For more information see: http://www.nami.org/ and www.mentalhealthfirstaid.org

Project 1: Community Trainings for Potential Responders

- **Provider Education Program (PEP):** PEP was developed by NAMI and helps providers who work with individuals living with mental illness to understand the experiences of mental illness from the perspective of the individual and family member. The five 2.5 hour sessions help participants increase their empathy and professional skills. Two PEP classes will be offered per year.

- **Parents and Teachers as Allies:** The Parents and Teachers as Allies is a 2-hour in service program that helps school professionals identify the warning signs of early-onset mental illness in children and adolescents in school.

- **Crisis Intervention Training for Law Enforcement:** BHS works in partnership with the Sheriff and local police departments to offer crisis intervention trainings for law enforcement. Courses include an 8-hour POST-certified training curriculum (POST is the Peace Officer Standard and Training Commission for the State of California.) A 40-hour training is also available for officers designated as Mental Health Liaisons.

- **Mental Health First Aid:** Mental Health First Aid is an 8-hour course that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training teaches community members who to identify, understand, and respond to signs of addictions and mental illness. Two trainings are offered in San Joaquin County. Mental Health First Aid and Youth Mental Health First Aid.

- **Trauma-Informed Care:** Training will assist responders in recognizing trauma-related symptoms and concerns and in the interventions helpful to individuals affected by trauma.

Project 2: Community Education:

- **In Our Own Voices (IOOV):** IOOV are 60-90 minute presentations to illustrate the individual realities of living with mental illness. The objective is to change attitudes, preconceived notions and remove stereotypes regarding mental illness. Each year, 40 presentations are planned throughout the county (32 in English and 8 in Spanish).

- **Family to Family (F2F):** F2F is a 12-session educational program designed for family members of adults living with mental illness. The program is taught be trained teachers who are also family members and offers hope, inspiration, and practical tips for families supporting recovery and wellness efforts. It is a designated evidence based practices that has been shown to significantly improve coping and problem-solving abilities of the people closest to an individual living with a mental illness.

- **Peer to Peer (P2):** P2P program provides up-to-date research on brain biology, a personalized relapse prevention plan, tools to prepare for interactions with health care providers, and skills for decision-making and reducing stress. Classes are 10, 2-hour sessions designed for adults living with mental illness. Classes are offered in English and Spanish.

- **NAMI Basics:** A six-session class for parents and caregivers of children and adolescents who are experiencing symptoms of a mental illness or who have been diagnosed. The program offers facts about mental health conditions and tips for supporting children and adolescents at home, school, and when they are getting medical care.

PEI: Outreach-Increasing Recognition of Mental Illnesses

Cost Center(s): 6397
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total				**$0.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$20,112.17		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$2,808.75	$0.00	$75,000.00
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$5,388.44		$11,250.00
PERSONNEL COSTS	$24,304.58		$0.00
TOTAL GROSS EXPENDITURES	**$52,613.94**	**$0.00**	**$86,250.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$52,613.94**	**$0.00**	**$86,250.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Contracted trainers $30,000

Brief description of items included in Contracted Service Provider:

PEI Project 13: Information and Education Campaign

Community Need
Too many individuals remain unserved by community mental health services owing to negative feelings attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. The overarching purpose of the *PEI Information and Education Campaign* is to increase acceptance and understanding of mental illnesses and seeking mental health services; to increase help seeking behaviors; and to promote equity in care and reduce disparities in access to mental health services.

Project Description
BHS will work with a contracted program partner to develop, host, and manage a public information and education campaign intended to reduce multiple stigmas that have been shown to discourage individuals from seeking mental health services. The information and education campaign will include language, approaches, and social/media markets that are culturally and linguistically relevant and congruent with the values of underserved populations.

Project Goal: *To reduce stigma towards individuals with a mental illness and increase self-acceptance, dignity, inclusion and equity for individuals with mental illness and members of their family.*

Project Components

To develop and promote a public information and education campaign using: (1) positive, factual messages and approaches with a focus on recovery, wellness, and resilience; (2) culturally relevant language, practices, and concepts geared to the diverse population of San Joaquin County; and (3) straightforward terms – not jargon – to explain when, where, and how to get help.

Self-Acceptance: Understanding and accepting a mental health diagnosis can be a lengthy process for consumers and their family members; one made more difficult by a lack of relevant information. The primary focus of the *Information and Education Campaign* will be a re-imagining of how information about mental illness, treatment options, and pathways to services are made available to consumers and family members. Currently BHS and others rely heavily on website pages and brochures which provide relatively static information. With today's technology, there are better and more easily navigable ways to provide individualized information on mental illnesses and how to get the help needed. Accepting a diagnosis is easier when there are meaningful examples of recovery; accessible pathways to services; tangible recovery milestones; and clarity on when, why, and how treatment is escalated. A secondary purpose of this work will be to increase *timely* access to services for those first accepting a diagnosis of a mental illness.

Dignity: Promoting dignity in the delivery of mental health services is a fundamental value of San Joaquin County Behavioral Health Services. At BHS, consumer driven services are a fundamental tenant of how treatment and recovery plans are developed. The *Information and Education Campaign* will include the development of simple step-by-step instructions for consumers to develop their own recovery pathway. Specific education campaign items will be accessed through the web-site, touch screen portals, and informational brochures. Examples of the types of items that will be addressed include, but are not limited to: developing and updating a Wellness Recovery Action Plan (WRAP),

having a peer partner assigned; asking for a second opinion; patient rights, expectations for timely access to services; and escalating questions or concerns to a consumer advocate.

Inclusion: The target population for the *Information and Education* campaign will be all residents of San Joaquin County and it is important to provide education to people who are not actively seeking information on mental health issues such that there is broader acceptance of behavioral health concerns as a normalized experience; and a broader acceptance of people with mental illnesses in classrooms, workplaces, on playgrounds, and in the community. Hence, some efforts are needed to ensure that the education materials designed to reduce stigma towards mental illness are broadly accessible in the community: on billboards, information kiosks, and prominently posted in public locations such as libraries, community colleges, post offices, court houses.

Equity: Equity means equal access to services; but it also means equal inclusion in the development of services and supports, the information that is generated about services and supports, and in the distribution of information and education materials. In developing a stigma and discrimination reduction campaign that is linguistically competent and culturally congruent to the values of the population the developers of the *Information and Education Campaign* will engage consumers, family members, youth, and underserved communities to provide guidance and feedback on the development of the *Information and Education Campaign.* At a minimum it is anticipated that *Information and Education Campaign* materials will be developed in English and Spanish and that a targeted information and education campaign will be developed for Spanish-speaking residents of San Joaquin County which may include billboards, social media, or other public or direct-contact approaches.

PEI: Information and Education Campaign

Cost Center(s): 6392, 6397 Nothing from 6397
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total					**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS			$217,541.00
NON-RECURRING COSTS (Equipment, Technology, etc)			
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)			
CONTRACTED SERVICE PROVIDER			$1,739,130.00
ADMINISTRATIVE / INDIRECT			$260,870.00
PERSONNEL COSTS			$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$2,217,541.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$2,217,541.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

CalMHSA PEI Sustainablity Funding $217,541

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP

PEI Project 14: Suicide Prevention with Schools

Community Need
Suicide is a preventable consequence of untreated mental illnesses. Suicide prevention campaigns can effectively reduce the stigma associated with seeking mental health services and provide and promote suicide prevention resources, including alert helpers to link individuals to services. Broad suicide prevention strategies are needed to reduce stigma for help seeking behaviors and to increase awareness of suicide risk in San Joaquin County amongst children, youth, and adults.

Project Description
The suicide prevention project will include both universal and targeted suicide prevention efforts.

- Comprehensive school-based suicide prevention programs for students in San Joaquin County. Targeted suicide prevention activities will include:
  - Evidence-based suicide education campaigns.
  - Depression screenings and referrals to appropriate mental health interventions.

Project Goal: *The project is designed to identify and refer individuals at risk of self-harming and suicidal behaviors and to reduce stigma for help-seeking behavior.*

Project Components:

Suicide Prevention with Schools – Develop comprehensive school-based suicide prevention and education campaign for school personnel and students. Activities include depression screening and referral services which will result in the timely identification and referral of students at risk of self-harming and/or suicidal behaviors to mental health services. Programs must operate in partnership with one or more schools or school districts. At a minimum the program will include:

- School personnel will be trained in an evidence-based practice to understand suicide, recognize suicide risk behavior in students, and to refer students for assistance, and
- Students at participating schools will receive evidence-based suicide prevention education.

<u>Component 1: An Evidence-Based Suicide Education Campaign</u>
Implement one or more of the following evidence-based practices for both school personnel and students:

- <u>Yellow Ribbon Suicide Prevention Campaign</u>
  Implement the evidence-based *Yellow Ribbon Campaign* with its four essential stages:
  - Planning sessions with school leaders;
  - *Be a Link® Adult Gatekeeper Training* for school personnel and *Ask 4 Help® Youth Gatekeeper Training* for youth leaders, followed by school-wide student assemblies;
  - Booster training and training for new staff members and students; and
  - Establishment of community task forces to ensure ongoing resource connections, awareness reminders, event coordination, and expanded gatekeeper training.

  The *Yellow Ribbon Suicide Campaign* will be implemented in accordance with the evidence-based practice. See: http://www.mhawisconsin.org/Data/Sites/1/media/gls/yellow_ribbon.pdf

- safeTALK Workshops
  Provide *safeTALK* workshops for individuals ages 15 and over at participating schools to assist in the recognition and identification of individuals with thoughts of suicide, and to connect them to mental health resources. *SafeTALK* will be implemented in accordance with the evidence-based program detailed at: https://www.livingworks.net/programs/safetalk/

  SafeTALK workshops teach youth to be "alert helpers" who are better able to move beyond common tendencies to miss, dismiss, or avoid suicide; to identify individuals with suicidal thoughts; and to help connect a person with suicidal thoughts to suicide intervention responders.

  SafeTALK includes the following practice requirements:
  - Workshops must be conducted by a registered safeTALK trainer and held over three consecutive hours;
  - A community support resource (such as a trained volunteer, safety officer, or mental health professional) must be present to support any participants who experience difficulty;
  - Each workshop will have between 10 and 30 participants.

  Workshop materials, including participant workbooks, wallet cards, and stickers, are available from LivingWorks (https://www.livingworks.net/programs/safetalk/).

Component 2: Depression Screening and Referral

Provide depression screenings and referrals on school sites for high-school students throughout San Joaquin County. Screenings will be delivered by qualified personnel and provided to adolescents exhibiting signs of depression. An evidence-based screening tool will be used. Potential depression screening tools include but are not limited to:

- *Patient Health Questionnaire-9 for Adolescents* **-** Depression is common among adolescents. In response to the growing evidence for effective treatments for depression among adolescents, the US Preventive Services Task Force now recommends screening for depression among adolescents in primary care settings. The PHQ-9 has good sensitivity and specificity for detecting major depression among adolescents in the primary care setting. For more information on the PHQ-9 see: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/
- *Center for Epidemiological Studies Depression Scale for Children* - (CES-DC) is a 20-item self-report depression inventory used as initial screener and/or measure of treatment progress. Scores may indicate depressive symptoms in children and adolescents as well as significant levels of depression. For more information on CES-DC see: http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf

Following the screenings, youth may be referred to one or more of the following: individual therapy with a qualified mental health clinician; further assessments and screenings for medication evaluation; and/or school-based depression support groups.

PEI: Suicide Prevention with Schools

Cost Center(s): 6397
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total				**$0.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$193,889.23		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$5,617.50		
CONTRACTED SERVICE PROVIDER	$488,724.72	$254,331.00	$592,248.00
ADMINISTRATIVE / INDIRECT	$88,865.83		$88,837.00
PERSONNEL COSTS	$24,926.85		$0.00
TOTAL GROSS EXPENDITURES	**$802,024.13**	**$254,331.00**	**$681,085.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$802,024.13**	**$254,331.00**	**$681,085.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

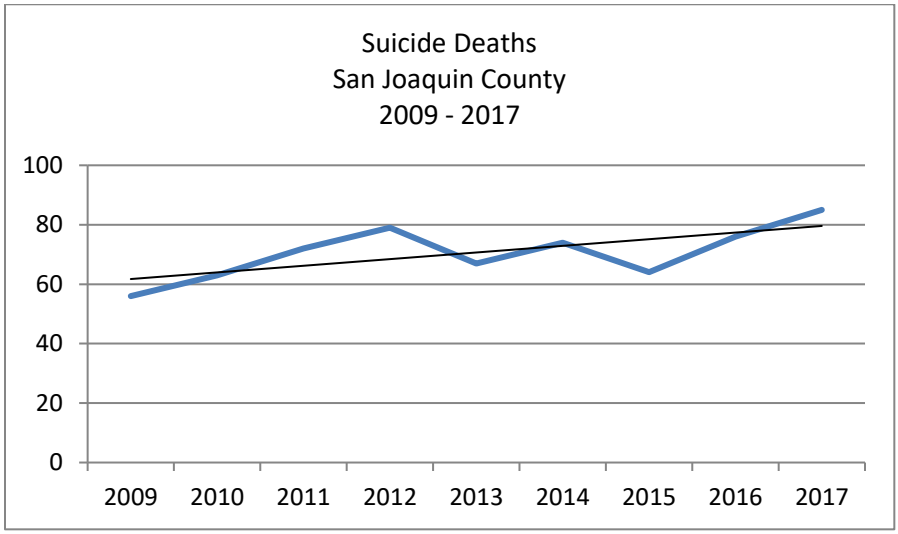
Brief description of items included in Contracted Service Provider:

Child Abuse Prevention Council $592,248

PEI Project 15: Suicide Prevention in the Community

Community Need

There is an increase in the numbers of suicide deaths occurring over the past 10 years, according the Office of the Coroner, and as shown in the chart below. Increases are somewhat higher than the prior 10 years in which suicides deaths were relatively flat, accounting for between 50 – 60 deaths annually. This is consistent with national research which shows that while suicide rates remained relatively stable between the late nineties and mid-2000's there is a significant increase in suicide deaths in the last ten years[1].



Suicide is the preventable consequence of untreated mental illness. PEI currently funds a suicide prevention campaign in local schools. Additional resources are needed for a suicide prevention campaign targeting adults and older adults.

National data also indicates that the suicide prevention activities need to better target males, who account for the majority of suicide deaths (75% of suicides nationally, and 85% of San Joaquin's suicide deaths, in 2017); and need to better target young men and adults between the ages of 15 – 64 with special outreach to young men and adults living in non-urban areas.

Project Description

In coordination with the PEI *Information and Education Campaign* BHS will work with a contracted program provider to develop a local suicide prevention campaign targeting young men and adults between the ages of 15-64. Suicide prevention campaign information will align its messaging with existing major suicide prevention initiatives, including national suicide prevention hotline and text lines,

[1] See: Centers for Disease Control and Prevention, National Center for Health Statistics, *Suicide Mortality in the United States 1999 – 2017.* https://www.cdc.gov/nchs/products/databriefs/db330.htm

while simultaneously promoting local resources for a range of wellness concerns including depression, anxiety, and stress management.

Project Goal: *Increase awareness and understanding of suicide as an illness and how to connect with a mental health professional in the community to address suicide thoughts or planning for yourself or a friend.*

Project Components

Project 1: Suicide Prevention for the Community

Develop and promote a suicide prevention and information campaign using a range of multi-media platforms, including billboards, websites, social media and/or smart-device applications which will guide users to local resources in San Joaquin County. Gun violence is the most prevalent mode of suicide death in San Joaquin County. Suicide prevention and information campaign efforts will include facts about non-homicide firearm related deaths and measures that can be taken to limit easy access to a gun for someone who may be at risk for suicide.

Additionally some San Joaquin County funds are assigned to CalMHSA for statewide suicide prevention programs.

PEI: Suicide Prev-Suicide Prevention for the Community

Cost Center(s): 6392
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total				**$0.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS			
NON-RECURRING COSTS (Equipment, Technology, etc)			
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)			
CONTRACTED SERVICE PROVIDER			$652,174.00
ADMINISTRATIVE / INDIRECT			$97,826.00
PERSONNEL COSTS			$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$750,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$750,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP

VII. Innovation

Innovation Component Funding Guidelines:

INN Projects are novel, creative, and/or ingenious mental health practices/approaches that contribute to learning and that are developed within communities through a process that is inclusive and representative, especially of unserved, underserved and inappropriately served individuals.

Innovation funding may be used for the following purposes:

- Increase access to underserved groups
- Increase the quality of services including better outcomes
- Promote interagency collaboration
- Increase access to services

The primary purpose of an Innovation Project is to contribute to learning, rather than a primary focus on providing services. Contributions to learning can take any of the following forms:

- Introduce new mental health practices /approaches, including prevention and early intervention
- Adapt or change an existing mental health practice/ approach including adapting to a new setting or community
- Introduce a new application for the mental health system of a promising practice or an approach that has been successful in a non-mental health context or setting

INN Projects must also consider the following general standards, though the extent to which they are addressed will vary by INN Project:

- Community Collaboration
- Cultural Competence
- Client Driven Mental Health System
- Family Driven Mental Health System
- Wellness Recovery and Resilience Focus
- Integrated Service Expansion

BHS received approval by the Mental Health Services Oversight and Accountability Commission in January 2018 to implement two INN programs.

Project 1: Assessment and Respite Center

Project 2: Progressive Housing

INN Project 1: Assessment and Respite Center

Community Need: There are significant barriers to accessing mental health treatment services for vulnerable and underserved populations. BHS utilization data reveals significant disparities in accessing timely and appropriate mental health treatment services, including: low penetration rates amongst Latinos; over utilization of emergency and crisis services by African Americans; and low engagement of individuals that have had at least one episode of homelessness within the past year.

The Challenge: A range of systemic challenges, many associated with the initial assessment process, continues to impede access and linkages to services amongst unserved and underserved individuals.

(1) There exists a confusing system whereby some services are only available through the primary healthcare system and others through a separate mental health system - depending on diagnosis and medical necessity. For most people, where to get help can be confusing;
(2) Some underserved and unserved populations are untrusting of County operated services and are reluctant to engage in public mental health services;
(3) Some individuals may not attend mental health services due to stigma; this bias usually does not apply to primary health care services;
(4) The assessment process is reported to be onerous, stigmatizing, and difficult to navigate – often requiring multiple appointments; and
(5) The clinical assessment process is less responsive to the presenting needs of individuals that are homeless and/or are under the influence than is recommended by consumers, case managers, and clinical staff.

The Solution: Community-based health centers are emerging as new partners in the provision of mild to moderate mental health treatment and substance use recovery services. Community clinics are less stigmatizing, and neighborhood based, making them easier to access for many individuals. Community health centers and mental health departments need to develop: (1) seamless protocols for joint screening and assessment – creating a no wrong door approach to services; and (2) a new approach to the assessment process that is responsive to the most pressing concerns expressed by individuals who are homeless, hungry, and/or under the influence – many of whom are unable or unwilling to complete the assessment process until their basic needs are met.

The Project: Integrate assessment and stabilization services within a community health clinic in order to provide timely, walk-in assessments, respite, brief interventions, medication assisted treatment services, mild-moderate mental health services, and other needed health care services. Re-design the assessment process so that is more flexible, culturally responsive, and appropriate for those with co-occurring disorders and/or basic needs that must be initially met. Offer direct linkages to a range of stabilization services including withdrawal management, housing, respite, and case management in order to stabilize high-risk individuals and successfully engage them into treatment services.

This project will operate within a continuum of services that includes:

(1) Whole Person Care Homeless Outreach Teams;
(2) Proposition 47 funded Withdrawal Management and Case Management Services; and

(3) Progressive Housing and other two other MHSA funded projects to increase the availability of housing for individuals with mental illnesses.

The project also aligns with the recommendations of the County's Homelessness Taskforce and the Stepping-Up Initiative Steering Committee.

The Partner: Community Medical Center is a federally qualified health center operating in San Joaquin County for over forty years. With over a dozen neighborhood clinics, they offer a range of linguistically and culturally competent primary health, behavioral health, and dental care services to over 80,000 low-income individuals annually. Over 80% of employees are racial and ethnic minorities.

The Goal: The Assessment and Respite Center (ARC) will begin operations at the CMC Waterloo Clinic. Within the first year it is anticipated that the ARC will serve 20 individuals a day. It is anticipated that demand will quickly exceed the facility capacity – a second program site will be created after the first year of operations. Simultaneously, CMC intends to adapt protocols for joint BHS-CMC screening and assessment processes throughout all of their CMC San Joaquin Clinics. This will allow CMC to offer coordinated mental health screening, assessment, and linkages to services amongst any of the existing 80,000 patients by the third year of the project.

The Learning Question: BHS seeks to understand whether the new assessment processes will result in more at-risk individuals completing assessments and successfully linking to services and supports. Additionally, the evaluation will determine if the new model of collaborative assessments within a primary care setting will result in greater utilization of mental health services by individuals from unserved/underserved communities. Program objectives are to:

(1) increase access to services among underserved populations, as measured by:
- increase the number of completed assessments,
- successful linkages to services,
- increase in planned service utilization, and
- increase service retention for underserved populations.

(2) Reduce the negative consequences of untreated mental illness, as measured by:
- improve consumer well-being as measured by the *Adult Needs and Strengths Assessment*
- reduce the number and/or duration of hospitalizations, jail stays, or homelessness among participants of intensive stabilization services provided through the ARC.

Sustainability: CMC's financial projections anticipate that within five years, the increased number of patients brought into CMC services through the expansion of behavioral health services will create a self-sustaining program over time. However, this project is a test of a method for improving access and linkages to services. Should the model prove successful, BHS may consider ongoing funding to support improved access and linkage to services through other MHSA component funding.

INN: Assessment & Respite Center

Cost Center(s): 6396
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total					**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00	$0.00	$108,900.00
CONTRACTED SERVICE PROVIDER	$0.00	$0.00	$2,088,277.00
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$2,197,177.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$2,197,177.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

UC Davis $108,900

Brief description of items included in Contracted Service Provider:

CMC $2,088,277

INN Project 2: Progressive Housing

Community Need: Individuals with a serious mental illness require a safe and stable place to live in order to engage in treatment services and meet recovery goals. However affordable housing options are scarce, putting many individuals with mental illnesses at risk of homelessness, jeopardizing recovery goals.

The Challenge: Housing rents have skyrocketed in San Joaquin County, (by 92% over the last five years), squeezing many individuals into an increasingly competitive rental market. Further, 257 beds in fifteen board and care homes have been lost due to facility closure over the past two years – nearly a quarter of the previously available housing opportunities. The challenge of finding solutions for homeless individuals with mental illnesses is also growing in San Joaquin County. The 2017 Point-in-Time Homelessness Count found over 1,550 homeless individuals, with 31% reporting a mental health concern.

For low-income individuals with co-occurring mental illnesses and substance use disorders, and with recent experiences of homelessness, finding a safe, affordable and stable place to live can be next to impossible. Many of these individuals end up homeless, living in motels, or living in substandard housing. This challenge is faced by counties throughout the State who struggle to secure housing for their mental health consumers.

The Solution: Develop a model of cost-effective recovery-oriented housing that moves individuals out of homelessness while simultaneously addressing substance use recovery, mental health treatment needs, and preparing individuals to live more independently.

The Project: Progressive Housing is a modified approach to Housing First, a promising practice of placing mentally ill consumers in housing as a precursor to treatment services. The Housing First model shows mixed results with reductions in arrests and emergency hospitalizations but no significant changes in recovery outcomes.

Progressive Housing places individuals in shared housing, with each home representing a different stage on the recovery continuum, including contemplation; active treatment; and sober living houses. This will help create a no fail approach by which individuals can move up and down the housing continuum based on their current stage within the recovery process. The shared housing approach also reduces per-person housing costs, reduces isolation, and introduces a peer support component.

Shared recovery oriented housing will further promote wellness, by reducing isolation and creating a supportive environment. Consumer choice programming will fund group recreation, learning, and wellbeing activities for residents to improve socialization and behavioral skills. Case management and treatment services will be leveraged through other MHSA component funding.

Progressive Housing will leverage additional program services in order to create a comprehensive program. Mental health services will be provided for all consumers with serious mental illnesses through existing programs. Individuals identified with mild/moderate mental health concerns may be

treated through a partnership with Community Medical Centers. Primary health care services, case management, and other wraparound services will also be leveraged through existing programs. Clients will be asked to contribute a nominal portion of their personal income from Social Security or General Assistance to their own cost of living for food and sundries; this helps build personal responsibility and prepare consumers for more independent living arrangements. All houses will keep basic pantry supplies and necessities stocked to assure no one is hungry. Contributions to the general food budget will vary based on the recovery stage of the clients in the house.

The Partner: Stockton Self Help Housing has over 30 years-experience in creating housing opportunities for homeless individuals.

The Goal: Progressive Housing hopes to open six houses annually for the first three years, serving approximately 90 enrolled clients by project termination. Program goals include increased access to and participation in treatment services, increased housing stability, and decreased the negative consequences of untreated mental illnesses.

The Learning Question: BHS will test whether this adaptation results in increased retention in services, successful client outcomes; is more cost effective than other models of developing new affordable housing (such as purchase, lease or construction); and whether the model can be replicated and rapidly deployed such that it can be expanded to other jurisdictions depending on need and market conditions.

Sustainability: Over the long term BHS seeks to determine if the Progressive Housing model will result in improved outcomes for consumers, including better engagement with treatment services, for a target population of consumers with co-occurring disorders, homelessness or prior incarcerations which limit access to other affordable housing solutions.

The evaluation will seek to determine which components of the program model are most linked to the outcomes realized. For example, will the emphasis on peer partners, consumer choice programming, etc. result in better outcomes than Housing First as usual. Based on evaluation findings, BHS will evaluate which program components need to be sustained over the long term, although the primary project components (e.g. rent for housing and mental health treatment services) will continue for all individuals that remain engaged in the program.

INN: Progressive Housing

Cost Center(s): 6396
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Project Director	0.15			$14,252.00	$6,929.00
Housing Liaison	0.25			$14,285.00	$8,886.00
Peer Partners	1.50			$32,092.00	$21,264.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$60,629.00	**$37,079.00**
Total				**$97,708.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00	$139.71	$50,200.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00	$0.00	$108,900.00
CONTRACTED SERVICE PROVIDER	$28,519.61	$154,715.45	$1,193,000.00
ADMINISTRATIVE / INDIRECT	$18,582.00		$38,521.00
PERSONNEL COSTS	$0.00	$42,413.80	$97,708.00
TOTAL GROSS EXPENDITURES	**$47,101.61**	**$197,268.96**	**$1,488,329.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$47,101.61**	**$197,268.96**	**$1,488,329**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

prised of general operating service and supply costs required to support the INN Program as outline in the MHSOAC approved plan.

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

VIII. Workforce Education and Training

The Mental Health Services Act (MHSA) allocates funding to promote professional growth and development, including recruitment and retention programs, in order to remedy the shortage of qualified individuals to provide services to address severe mental illness.

"Workforce Education and Training" means the component of the Three-Year Program and Expenditure Plan that includes education and training programs and activities for prospective and current Public Mental Health System employees, contractors and volunteers. *CA Code of Regulations § 3200.320*

Workforce Education and Training program planning is intended to provide opportunities to recruit, train, and retain employees broadly into the public mental health system, including employees of private organizations that provide publically funded mental health services. As such BHS has included a range of training opportunities within this Workforce Education and Training (WET) component section that are intended for both BHS and non-BHS employees, in order to promote the growth and professionalism of the entire mental health system of care. Additionally this WET Plan outlines an approach to promote professional growth and to recruit and retain highly qualified clinical staff into the public mental health care system.

Significant Considerations in Workforce, Education and Training

- ***Competition in Hiring:*** The new California Health Care Facility in Stockton, providing mental health treatment for seriously mentally ill inmates, has increased competition for highly qualified clinicians and mental health care providers, especially psychiatrists, clinicians, and psychiatric technicians.
- ***Shortage of Psychiatrists:*** The San Joaquin Central Valley has a severe shortage of trained psychiatrists, especially licensed child and geriatric psychiatrists, to meet the general population demand. Recruitment and retention of child psychiatrists continues to be challenging.
- ***Expanding Consumer Positions***: BHS has significantly increased hiring of consumer and peer employees. Additional training and support services are required to continue this expansion.
- ***Workforce Development***: BHS continues to recruit and train talented graduates of mental health programs and additional clinical supervisors are needed to help ensure that interns receive high caliber training and supervision, in order to provide evidence based treatment interventions with fidelity and to pass licensure examinations.
- ***New and Emerging Research:*** BHS is committed to providing treatment interventions that reflect best practices in recovery and in training practitioners throughout the County.

The MHSA Workforce Education and Training component contains five funding categories:

(1) Training and Technical Assistance

The Training and Technical Assistance Funding Category may fund: programs and/or activities that increase the ability of the Public Mental Health System workforce to support the participation of consumers and family members; increase collaboration and partnerships;

promote cultural and linguistic competence; develop and deliver trainings; and promote and support the *General Standards* of specialty mental health care services.

(2) Mental Health Career Pathway Programs

The Mental Health Career Pathway Programs Funding Category may fund: programs to prepare clients and/or family members of clients for employment; programs and that prepare individuals for employment in the Public Mental Health System; career counseling, training and/or placement programs; outreach and engagement in order to provide equal opportunities for employment to culturally diverse individuals; and supervision of employees in Public Mental Health System occupations that are in a *Mental Health Career Pathway Program*.

(3) Residency and Internship Programs

The Residency and Internship Programs Funding Category may fund: time required of staff to supervise psychiatric or physician assistant residents and clinician or psychiatric technicians interns to address occupational shortages identified in the *Workforce Needs Assessment*.

(4) Financial Incentive Programs

The Financial Incentive Programs Funding Category may fund: financial assistance programs that address one or more of the occupational shortages identified in the County's *Workforce Needs Assessment*. Financial Incentive Programs may include scholarships, stipends, and loan assumption programs.

(5) Workforce Staffing Support

The Workforce Staffing Support Funding Category may fund: Public Mental Health System staff to plan, recruit, coordinate, administer, support and/or evaluate Workforce Education and Training programs and activities; staff to provide ongoing employment and educational counseling and support to consumers and family members entering or currently employed in the Public Mental Health System workforce, and to support the integration into the workforce; and other staff time, including the required Workforce Education and Training Coordinator, as necessary to implement the WET plan.

In 2018/19 BHS will refund the Workforce Education and Training projects with a transfer of funds into the WET account from CSS. Funds must be spent within 10 years from the date of transfer.

WET Project 1: Training and Technical Assistance Academy

Community Workforce Need

Consumers, family members, and program staff from public and community-based organizations throughout the County are critical partners in the delivery of mental health services. These volunteers and employees work tirelessly to promote mental health recovery and are a core component of the public mental health workforce and intricate to the BHS belief and commitment to consumer and family driven mental health care services. These professionals and community volunteers require ongoing training and education to promote their competencies and to improve the capacity of the entire workforce to provide culturally competent, high quality mental health services and supports.

Project Description

BHS will coordinate the delivery of trainings throughout San Joaquin County. Trainings will support the delivery of high quality, culturally competent, and consumer- and family-driven mental health services and supports. Trainings will also help establish and re-affirm a core practice model by establishing the baseline knowledge and competencies required to participate in the delivery of recovery oriented mental health service and supports.

Project Components

- *Trainings for Volunteers, Peer Partners, Case Managers, and Community Partners.* All volunteers, peer partners (consumers and family members), case managers and non-clinical community partners contracted to provide direct mental health services and supports shall be trained in the fundamentals of mental health, including how to engage and refer individuals for further assessment and interventions. Trainings for BHS staff, volunteers and community partners may include, but are not limited to, the following:
    - *Suicide Prevention and Intervention Trainings*
    - *Mental Health First Aid*
    - *Wellness Recovery Action Plans*
    - *Crisis Intervention Training (for Law Enforcement and first responders)*
    - *Trauma Informed Care*
    - *Addressing the needs of Commercially and Sexually Exploited Children*
    - *Motivational Interviewing*
    - *Stigma Reduction*
- *Specialty Trainings in Treatment Interventions.* Specialty trainings are provided to increase the competencies of staff in core practice modalities. These modalities include the delivery of evidence-based interventions, to fidelity, and as described throughout this MHSA plan. Trainings may include, but are not limited to, the following treatment interventions:
    - *Seeking Safety*
    - *Cognitive Behavioral Therapies*
    - *Dialectical Behavioral Therapy*
    - *Multisystemic Therapy*

- *Medication Assisted Treatment.* Medication Assisted Treatment (MAT), combines psychosocial modalities, including behavioral therapies and counseling, with medications for the treatment of substance use disorders. MAT is indicated for individuals with co-occurring mental health and substance use disorders. Funding will be allocated for BHS and some community partners to attend national medical conferences on the treatment of substance use, and co-occurring substance use, disorders in order to improve physician/psychiatrist knowledge and familiarity with MATs and the recommended prescribing protocols. The conferences' MAT training modules are designed to increase prescriber confidence and comfort in using MATs in conjunction with other psychotropic medications ordered for mental health illnesses.

- *MHSA General Standards Training and Technical Assistance.* BHS managers will receive training, guidance, and supervision to support and promote the MHSA and the General Standards of the MHSA. The Medical Director will provide training, guidance, and supervision to support and promote the MHSA and the General Standards of the MHSA amongst the medical staff. Training, guidance and supervision is provided to support and promote:
    - *Community Collaboration,* including efforts to integrate primary and mental health services and to provide mental health services within community-based locations throughout San Joaquin County.
    - *Cultural Competence,* including the use of culturally competent prevention, intervention, treatment and recovery approaches and culturally and linguistically appropriate discourse with consumers and family members.
    - *Client Driven Services*, including the incorporation of WRAP activities and plans within the clinical model, and practices which embraces the client as having the primary decision-making role in identifying his/her needs and preferences in service delivery.
    - *Family Driven Services,* including practices which incorporate the input of families within the development of treatment plans and in which the families of children and youth with SED/SMI have the primary decision-making role in the care of their own children.
    - *Wellness, Recovery, and Resiliency,* including supervision and guidance to ensure that all medical staff promote and support clients on their pathways to wellness and recovery.
    - *Integrated Service Experience,* including training or support to ensure that medical staff have the tools, training, and resources to access a full range of services provided by multiple agencies and programs in a comprehensive and coordinate manner.
    - *Leadership Training* for program managers to improve capacity for program design, management, and oversight, including contract compliance and evaluation.
    - *Compliance with Applicable Regulations.* As statewide regulations are updated to improve services staff require briefings and trainings to ensure that services continue to meet all standards and expectations.
    - *Electronic Health Records.* WET funding may be allocated to train BHS staff on the new electronic health information system.

BHS Training Coordinator. The BHS Training Coordinator manages the increasing training needs for BHS staff and community partners, including law enforcement. The training coordinator is responsible for working with the training divisions of local police and Sheriff and school districts to ensure that mental health related trainings are offered concurrent to professional growth and training plans of partner agencies. The training coordinator also develops and tracks participation in a range of MHSA related trainings for BHS staff and community partners as identified elsewhere in this Plan or as deemed necessary by BHS.

The Training Coordinator will also ensure that notifications about additional training opportunities will be distributed to the public mental health workforce, including consumers and family members of consumers who are interested in entering the mental health workforce.

Project Objectives

MHSA Training programs will increase the ability of BHS, and its community partners in mental health services, to deliver high quality, recovery oriented, and consumer- and family-driven specialty mental health care services by a culturally competent workforce throughout San Joaquin County. (See also, MHSA General Standards, *CA Code of Regulations §3320*.)

WET: Training & Technical Assistance Academy

Cost Center(s): 6399
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
Administrative Assistant II	1.00			$61,914.00	$44,684.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$61,914.00	**$44,684.00**
Total				**$106,598.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$301,240.50	$3,000.00	$1,299.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		$243,402.00
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$48,242.00	$450.00	$52,695.00
PERSONNEL COSTS	$260,690.50		$106,598.00
TOTAL GROSS EXPENDITURES	**$610,173.00**	**$3,450.00**	**$403,994.00**
Offsetting Revenue			
Medi-Cal			
Realignment			
Other			
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$610,173.00**	**$3,450.00**	**$403,994.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

To support BHS Training Academy

Brief description of items included in Contracted Service Provider:

IX. Capital Facilities and Technological Needs

Funding for capital facilities is to be used to acquire, construct, and/or renovate facilities that provide services and/or treatment for those with severe mental illness, or that provide administrative support to MHSA funded programs.

Funding for technological needs is to be used to fund county technology projects with the goal of improving access to and delivery of mental health services.

San Joaquin County submitted a Capital Facilities and Technology Needs (CFTN) Plan in spring 2013. The plan set aside funding for capital facilities construction and described a major capacity building project to bring the county into compliance with state and federal mandates for electronic health records.

Since 2013, additional needs have been identified and have been subsequently described in the 2017/18 Three Year Program and Expenditure Plan.

Past CFTN funding has been used to:

- Construction and Renovations to the Crisis Stabilization Unit
    - Create a CSU for children and youth
    - Create voluntary CSU for adults

- Electronic Health Records
    - Develop new electronic health records for consumers, update electronic case management and charting system
    - Develop data capacity and partnership protocols for information sharing through new health information exchange

In 2019/20 BHS will refund the Capital Facilities and Technology Needs project fund with a transfer of funds into the CFTN account from CSS. Funds must be spent within 10 years from the date of transfer. Proposed new projects are outlined described below.

CF/TN Project 1: Residential Treatment Services Facility for Individuals with Co-Occurring Disorders

There is an acute shortage of residential substance use disorder treatment services in San Joaquin County. Further, none of the existing programs are well equipped to provide recovery services for individuals with serious mental illnesses. Consumers and family members have expressed concern that recovery programs geared towards treating substance use disorders alone are not clinically the best option for the treatment of co-occurring disorders. BHS will continue to explore funding and procurement options, and may elect to use CFTN funds to renovate, purchase, or build a residential treatment program for individuals with co-occurring disorders. Additional activities may include, but are not limited to preliminary architectural design, site mapping, procurement, and other technical assistance. Funds are allocated for project start-up in FY 2019-20. Budget estimates presumes additional funds will be required in subsequent years to complete the project.

CF/TN Project 2: Facility Renovations

Funding will be allocated to upgrade and renovate Behavioral Health facilities. Capital Facility funds will be used for projects that have been identified as critical to ensuring clean, safe, and accessible access to services for all populations. Projects include: installation of security cameras, dedicated parking for the Children's Crisis services, restroom upgrades (for ADA compliance and safety), exterior painting to prevent structural damage, and other facility renovations.

CF/TN Project 3: Facility Repair and Upgrades

Funding will be allocated for a variety of facility repairs and upgrades to ensure facilities remain in good working order and provide comfortable and effective workspaces for all program activities. Projects include, but are not limited to: repairs or upgrades to flooring, workstations, meeting rooms, waiting rooms, and other public spaces; repairs or upgrades to heating and ventilation equipment, lighting, alarms, windows, acoustics, etc.; and other projects as needed to ensure that BHS facilities are in good repair and working order. Projects may include additional refurbishments to ensure that all clinical spaces are warm and inviting places that support healing and recovery. Upgrades may include interior re-configurations to accommodate increased staffing, new technologies, or other changes to "back-office" services needed to improve overall service delivery.

CF/TN Project 4: Technology Equipment and Software

Additional technology upgrades are needed. Software upgrades and equipment are necessary to ensure compatibility with the latest versions of financial, HR, project, and client case management systems, and to ensure all information is protected and retained in the event of an emergency. CF/TN funds will be used for a range of software, hardware, networking, and technology consultations to improve client services.

CFTN: Capital Facilities - Residential Treatment Facilities for COD

Cost Center(s):
RU(s):

PERSONNEL COSTS

Position Description & Position #	FY19-20 Proposed Budget FTE	Base Salary	Base Benefits	MHSA Salary	MHSA Benefits
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
Moved to Capital Facilites - Crisis and Acute Care Services Expansion				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
Total				**$0.00**	**$0.00**

	FY17-18 ACTUALS	FY18-19 YTD, 2.28.2019	FY19-20 PROPOSED BUDGET *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		$2,434,786.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$2,434,786.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$2,434,786.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CFTN: Capital Facilities-Facility Renovations

Cost Center(s):
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total					**$0.00**

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		
NON-RECURRING COSTS (Equipment, Technology, etc)	$0.00		$1,935,173.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00		
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$1,935,173.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$1,935,173.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Planning and Development for CRT for Children

Brief description of items included in Contracted Service Provider:

CFTN: Capital Facilities-Facility Repair and Upgrades

Cost Center(s): 6316
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total				**$0.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$81,623.58	$7,504.00	
NON-RECURRING COSTS (Equipment, Technology, etc)	$222,473.42	$217,401.13	$1,243,000.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)	$0.00	$2,193.83	$0.00
CONTRACTED SERVICE PROVIDER	$0.00		
ADMINISTRATIVE / INDIRECT	$0.00		
PERSONNEL COSTS	$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$304,097.00**	**$227,098.96**	**$1,243,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$304,097.00**	**$227,098.96**	**$1,243,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Funding to cover MHSA related manintenance and grounds cost.

Brief description of items included in Non-Recurring Costs:

Facility Projects

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CFTN: Technology Needs-Technology Equipment and Software

Cost Center(s):
RU(s):

PERSONNEL COSTS

	FY19-20 Proposed Budget				
Position Description & Position #	**FTE**	**Base Salary**	**Base Benefits**	**MHSA Salary**	**MHSA Benefits**
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	$0.00
				$0.00	**$0.00**
Total				**$0.00**	

	FY17-18 ACTUALS	**FY18-19 YTD, 2.28.2019**	**FY19-20 PROPOSED BUDGET** *incl S&B (above)
OPERATING COSTS	$0.00		$0.00
NON-RECURRING COSTS (Equipment, Technology, etc)	$521,181.40		$574,000.00
CONSULTANT/CONTRACT COSTS (Clinical, Training, Facilitator, Evaluation)			$99,000.00
CONTRACTED SERVICE PROVIDER			$240,000.00
ADMINISTRATIVE / INDIRECT			
PERSONNEL COSTS			$0.00
TOTAL GROSS EXPENDITURES	**$521,181.40**	**$0.00**	**$913,000.00**
Offsetting Revenue			
Medi-Cal	$0.00		
Realignment	$0.00		
Other	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$521,181.40**	**$0.00**	**$913,000.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Digital Health Management Solution, PC/Tablet reserves, Network Equipment

Brief description of items included in Consultant/Contract Costs:

Clinician Gateway special project

Brief description of items included in Contracted Service Provider:

ECHO Sharecare development $240,000

X. MHSA Funds – Reduction of the Prudent Reserve Balance

A. Introduction and Overview

On August 14, 2019 San Joaquin County Behavioral Health Services (BHS) received information Notice (IN) 19-037 from California Department of Health Care Services (DHCS) Mental Health & Substance Use Disorders Services (MHSUDS).

The purpose of information Notice 19-037 was to inform counties of the following:

- Requirement to establish and maintain a prudent reserve that does not exceed 33 percent of the average community services and support (CSS) revenue received for Local Mental Health Services Fund in the preceding given years, and to reassess and certify the maximum amount every five years.
- Each county must calculate an amount to establish its prudent reserve that does not exceed 33 percent of the average amount allocated to the CSS Component in FY 2013-14, FY 2014-15, FY 2015-16, FY 2016-17, FY 2017-18. To determine the average amount allocated to the CSS Component of those five years a county must calculate the sum of all distributions form the Mental Health Services Fun from July 2013 through June 2018, multiply that sum by 76, and divide that product by five.
- To determine the maximum prudent reserve level, a county must multiply the average amount allocated to the CSS component of the previous five years by 33 percent.

In San Joaquin County the maximum prudent reserve funds should be as follows:

San Joaquin County		
Prudent Reserve Maximum		
June 30, 2019 Assessment		
		MHSF Distribution
FY 2013-14		$ 20,588,023.62
FY 2014-15		$ 28,683,962.64
FY 2015-16		$ 23,778,868.00
FY 2016-17		$ 31,240,367.33
FY 2017-18		$ 34,063,364.47
	Total	$ 138,354,586.06
CSS allocation (76%)		$ 105,149,485.41
5-Year Average		$ 21,029,897.08
Prudent Reserve Maximum (33% of 5-yr average)		**$ 6,939,866.04**

XI. Attachments: Evaluation and Planning Reports

1. Workforce Analysis
2. Cultural Competency Plan
3. PEI Evaluation

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT:

I. By Occupational Category - page 1

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist	5.75	0	0							
Case Manager/Service Coordinator	103.75	1	30							
Employment Services Staff	1.00	0	0							
Housing Services Staff	1.00	0	0							
Consumer Support Staff	44.75	1	8							
Family Member Support Staff	8.75	1	4							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	87.25	1	0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only) ↓						
Sub-total, A (County)	**252.25**	**4**	**42**	**61.75**	**78.00**	**34.25**	**20.25**	**1.00**	**15.50**	**210.75**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	24.35	0	3							
Case Manager/Service Coordinator	35.25	0	5							
Employment Services Staff	1.00	0	0							
Housing Services Staff	4.50	0	0							
Consumer Support Staff	38.00	0	0							
Family Member Support Staff	2.00	0	0							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	38.27	0	0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ↓						
Sub-total, A (All Other)	**143.37**	**0**	**0**	**40.74**	**55.24**	**15.38**	**21.70**	**2.75**	**7.56**	**143.37**
Total, A (County & All Other):	**395.62**	**4**	**42**	**102.49**	**133.24**	**49.63**	**41.95**	**3.75**	**23.06**	**354.12**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	Race/ethnicity of FTEs currently in the workforce – Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general	14.63	1	9							
Psychiatrist, child/adolescent	5.12	1	6							
Psychiatrist, geriatric	2.00									
Psychiatric or Family Nurse Practitioner	2.75	1	0							
Clinical Nurse Specialist										
Licensed Psychiatric Technician	68.25	1	8							
Licensed Clinical Psychologist										
Psychologist, registered intern (or waivered)										
Licensed Clinical Social Worker (LCSW)	14.75	1	8							
MSW, registered intern (or waivered)	27.25	1	14							
Marriage and Family Therapist (MFT)	27.00	1	8							
MFT registered intern (or waivered)	42.25	1	13							
Other *Licensed* MH Staff (direct service)	6.75	1	6							
Sub-total, B (County)	**210.75**	**9**	**72**	**56.35**	**50.50**	**19.75**	**51.75**	**0**	**19.10**	**197.45**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	3.25	1	2							
Psychiatrist, child/adolescent	.20	1	3							
Psychiatrist, geriatric										
Psychiatric or Family Nurse Practitioner		1								
Clinical Nurse Specialist	3.75	1	4							
Licensed Psychiatric Technician	2.10									
Licensed Clinical Psychologist										
Psychologist, registered intern (or waivered)	5.85	1	2							
Licensed Clinical Social Worker (LCSW)	4.65	1	4							
MSW, registered intern (or waivered)	21.70	1	2							
Marriage and Family Therapist (MFT)	13.85	1	4							
MFT registered intern (or waivered)	0	1	2							
Other *Licensed* MH Staff (direct service)										
Sub-total, B (All Other)	**55.35**	**9**	**23**	**15.79**	**14.15**	**5.55**	**14.51**	**0**	**5.35**	**55.35**
Total, B (County & All Other):	**266.10**	**18**	**95**	**72.14**	**64.65**	**25.30**	**66.26**	**0**	**24.45**	**252.80**

(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only)

(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only)

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes' 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician	0									
Registered Nurse	23.50	1	3							
Licensed Vocational Nurse	1.0									
Physician Assistant	0									
Occupational Therapist	1.0									
Other Therapist (e.g., physical, recreation, art, dance)	0									
Other Health Care Staff (direct service, to include traditional cultural healers)	25.0	1	0	(Other Health Care Staff, Direct Service; Sub-Totals Only) ⬇						
Sub-total, C (County)	**50.50**	**2**	**3**	**19.75**	**7.0**	**4.50**	**13.25**	**0**	**3.75**	**48.25**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	0									
Registered Nurse	0	1	0							
Licensed Vocational Nurse	1.50	1	0							
Physician Assistant	0									
Occupational Therapist	0									
Other Therapist (e.g., physical, recreation, art, dance)	0									
Other Health Care Staff (direct service, to include traditional cultural healers)	1.20			(Other Health Care Staff, Direct Service; Sub-Totals and Total Only) ⬇						
Sub-total, C (All Other)	**2.70**	**2**	**0**	**1.20**	**1.50**					**2.70**
Total, C (County & All Other):	**53.20**	**4**	**3**	**20.95**	**8.50**	**4.50**	**13.25**	**0**	**3.75**	**50.95**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce – Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor.....	13.00									
Supervising psychiatrist (or other physician)	1.00									
Licensed supervising clinician.....	23.00	1	4							
Other managers and supervisors.....	33.00	1	4							
Sub-total, D (County)	**70.00**	**2**	**8**	**33.00**	**11.00**	**5.00**	**11.00**	**2.00**	**2.00**	**64.00**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor.....	6.72									
Supervising psychiatrist (or other physician)	0									
Licensed supervising clinician.....	4.25	1	4							
Other managers and supervisors.....	9.98									
Sub-total, D (All Other)	**20.95**	**1**	**4**	**7.96**	**5.00**	**4.73**	**2.26**	**0**	**1.00**	**20.95**
Total, D (County & All Other):	**90.95**	**3**	**12**	**40.96**	**16.00**	**9.73**	**13.26**	**2.00**	**3.00**	**84.95**
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance.....	**27.75**	**1**	**15**							
Education, training, research	**0**									
Clerical, secretary, administrative assistants	**142.25**									
Other support staff (non-direct services).....	**28.75**									
Sub-total, E (County)	**198.75**	**1**	**15**	**54.00**	**50.75**	**15.25**	**18.50**	**.75**	**12.75**	**152.00**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance.....	**1.45**									
Education, training, research	**0**									
Clerical, secretary, administrative assistants	**12.95**									
Other support staff (non-direct services).....	**2.0**									

(Managerial and Supervisory; Sub-Totals Only)

(Managerial and Supervisory; Sub-Totals and Total Only)

(Support Staff; Sub-Totals Only)

(Support Staff; Sub-Totals and Total Only)

Sub-total, E (All Other)	16.40	0	0	6.15	2.37	1.00	1.43	0	5.45	16.40
Total, E (County & All Other):	215.15	1	15	60.15	53.12	16.25	19.93	.75	18.20	168.40

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 5

GRAND TOTAL WORKFORCE
(A+B+C+D+E)

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
County (employees, independent contractors, volunteers) (A+B+C+D+E).....	**782.25**	**18**	**140.00**	**224.85**	**197.25**	**78.75**	**114.75**	**3.75**	**53.10**	**672.45**
All Other (CBOs, CBO sub-contractors, network providers and volunteers) (A+B+C+D+E)	**238.77**	**12**	**27.00**	**71.84**	**78.26**	**26.66**	**39.90**	**2.75**	**19.36**	**238.77**
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	**1,021.02**	**30**	**167.00**	**296.69**	**275.51**	**105.41**	**154.65**	**6.50**	**72.46**	**911.22**

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served – Col. (11)						
				White/ Cau-casion	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	All individuals **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			**6,827**	**4,609**	**3,270**	**1,814**	**518**	**791**	**17,829**

II. Positions Specifically Designated for Individuals with Consumer and Family Member Experience:

Major Group and Positions	Estimated # FTE authorized and to be filled by clients or family members	Position hard to fill with clients or family members? (1=Yes; 0=No)	# additional client or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff	63.85	1	8
Family Member Support Staff	11.75	1	4
Other *Unlicensed* MH Direct Service Staff	0	1	
Sub-Total, A:	**75.60**	**3**	**12**
B. *Licensed* Mental Health Staff (direct service)	**0**	**0**	
C. Other Health Care Staff (direct service)	**0**	**0**	
D. Managerial and Supervisory	**2.50**	**0**	
E. Support Staff (non-direct services)	**9.15**	**0**	
GRAND TOTAL (A+B+C+D+E)	**87.25**	**0**	**12**

III. LANGUAGE PROFICIENCY

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the language, (3) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3):

Language, other than English (1)	Number who are proficient (2)	Additional number who need to be proficient (3)	TOTAL (2)+(3) (4)
1. Spanish (threshold)	Direct Service Staff 126 Others 39	Direct Service Staff 52 Others 0	Direct Service Staff 178 Others 39
2. Cambodian (threshold)	Direct Service Staff 8 Others 2	Direct Service Staff 1 Others 0	Direct Service Staff 9 Others 2
3. Vietnamese	Direct Service Staff 11 Others 1	Direct Service Staff 0 Others 0	Direct Service Staff 11 Others 1
4. Hmong	Direct Service Staff 9 Others 5	Direct Service Staff 0 Others 0	Direct Service Staff 9 Others 5
5. Lao	Direct Service Staff:1 Others: 0	Direct Service Staff: 2 Others 0	Direct Service Staff: 3 Others 0
6.Thai	Direct Service Staff: 3 Others: 0	Direct Service Staff: 0 Others: 0	Direct Service Staff: 3 Others: 0 Others
7 Tagalog/Filipino	Direct Service Staff 23 Others 7	Direct Service Staff 0 Others 0	Direct Service Staff 23 Others 7

Direct Ser

San Joaquin County Behavioral Health Services
2017-18 Annual Update to the 2010 Cultural Competency Plan

San Joaquin County Behavioral Health Services (BHS) continuously seeks to improve by evaluating, strategizing and enhancing service delivery in a broad range of behavioral health services that include mental health and substance use disorder services in a culturally competent and linguistic appropriate manner to meet the prevention, intervention, treatment and recovery needs of San Joaquin County residents.

This document serves as a brief annual update, reviewing the efforts of Fiscal Year 2017-2018 and to provide strategic guidance and baseline development on upcoming efforts for 2018-19. The Brief Annual update will focus on the eight criteria laid out by the State's Cultural Competency Plan Requirements of 2010, reflective of the current Medi-Cal population to provide strategies on improvement and enhancement of Culturally Competent and Linguistically Appropriate Services, for agency staff, community partners and consumers.

Criterion 1: Commitment to Cultural Competence
(CLAS Standard 2, 3, 4, 9, 15)

BHS identified three foundational areas in which it could improve its commitment to cultural competence: policy development, program development/adaption, and staff training. BHS developed a Cultural Competency Policy which expresses BHS's commitment to cultural competence and details the methods by which BHS will ensure culturally competent services.
BHS also developed on online Cultural Competency training for staff. The previous cultural competency training was provided in-person and participation in the training was variable. To ensure that the cultural competence training is widely available and to track employee compliance with training participation, the BHS Cultural Competency Committee developed an online training that could be taken at each employee's convenience, and for which participation could be tracked electronically.

2017-18 Accomplishments: Two significant strategies were implemented to enhance agency commitment to Cultural Competency. These were:

- A Cultural Competency Policy for the division (See attachment 1)
- An on-line training course in Cultural Competence for all BHS employees (See Attachment 2)

2018-19 Strategies: BHS plans to further enhance its cultural competence by developing:

- Plan to measure and monitor the cultural competency standards through the data dashboard and/ or the Quality Improvement Work Plan by June 30, 2019 (Completed 1/15/19: see FY 17/18 QAPI Workplan)
- Division-wide and program-specific inventory of Cultural Competency knowledge via the California Brief Multicultural Competence Scale (CMCBS) to identify gaps in the knowledge base of BHS Staff Members and Partners by June 30, 2019
- Strategies and an action plan to address findings of the CBMCS by June 30, 2019.
- Policies and programs to increase services for underserved populations, demonstrated by increasing Latino/Hispanic penetration rates.
- Treatment interventions designed to reduce cultural stress (i.e., perception of discrimination and negative sense of identity in relationship to social/family environment), demonstrated by decrease in Cultural Stress CANSA scores.

Criterion 2: Updated Assessment of Service Needs

(CLAS Standard 2)

BHS conducted assessments of service needs through three methods:

1. Mental Health Services Act (MHSA) Community Planning Process on the needs and gaps in services to diverse communities in the County. The assessment of service needs is detailed in the 2018-19 Annual Update to the Three Year program and Expenditure Plan on pages 6 through 15 (See attachment 3).
2. Review of county-specific Medi-Cal Approved Claims Data provided by CALEQRO. The data provided by CALEQRO contains Medi-Cal Beneficiaries served by race and ethnicity and penetration rates by age, gender and ethnicity (See attachment 4).
3. A survey of managers on Culturally and Linguistically Appropriate (CLAS) Standards.

Through its MHSA Planning Needs Assessment, BHS found that the diversity of its consumers was similar to the distribution in prior years.

- African Americans are disproportionately represented amongst consumers compared to their proportion of the general population (19% of participants, though comprising 7% of the population of the County).
- Latinos are enrolled as lower rates compared to their proportion of the general population (24% of participants while comprising 41% of the population) – though this rate is up slightly from prior years.
- Participation amongst children and youth is more reflective of the racial demographics of the overall population, with over a third of services provided to young Latinos (35%), suggesting that while stigma, language or cultural barriers, or access to health care services continue to impeded access for Latino adults with behavioral health needs more services are reaching the younger populations.

BHS also determined that no significant differences were noticeable with regards to how illnesses are distributed by race/ethnicity, though a slightly greater proportion of the individuals diagnosed with schizophrenia are African American (23% of all individuals diagnosed with schizophrenia) likely reflecting the overall overrepresentation of African Americans in treatment services.

Through its review of data provided by CALEQRO for Medi-Cal Beneficiaries served showed that

- The penetration rate for individuals 60+ is higher than the statewide average.
- The penetration rate for Asian/Pacific Islanders is higher than the statewide average.
- The penetration rate for Latino/Hispanic communities (2.53%) is lower than the statewide average of 3.38%.

From this data, the BHS Cultural Competency Committee determined that BHS should develop strategies to enhance outreach and engagement within Latino/Hispanic communities.

In July 2017, the Cultural Competency Committee presented on Culturally and Linguistically Appropriate (CLAS) Standards to the BHS Managers meeting and asked managers to complete a Survey on the extent to which BHS provides Cultural and Linguistic Appropriate Services with two goals: 1) collecting baseline data, and 2) creating awareness of CLAS standards among managers. In Fall 2017, the Cultural Competency Committee reviewed the results of the CLAS Standards survey and noted areas of success and concerns. Common themes in the survey results included:

- Continuous efforts to attract a diverse workforce, both among line staff and management staff, including individuals who are proficient in languages other than English
- Staff training on diversity.
- Outreach services for individuals with limited English proficiency
- A need to improve the number of printed materials available in languages other than English.
- Better data collection on ethnicity and race
- Improved data-driven decision making for culturally and linguistically appropriate services.

2017-18 Accomplishments: BHS implemented a comprehensive community planning process that included:

- Six community discussions and about the needs and challenges experienced by mental health consumers with a focus on the diverse range of consumers served.
- Five targeted discussion groups with mental health consumers, family members and community stakeholders.
- Assessment of program services, including utilization, timeliness and client satisfaction.
- Cultural Competency Committee presentation to managers on CLAS Standards
- Administration of survey on CLAS Standards to BHS Managers.

2018-19 Strategies:

- Conduct a series of MHSA community planning discussions on the needs and challenges experienced by mental health consumers with a focus on the diverse range of consumers served by November 30, 2018.
- Develop online and paper needs assessment surveys to reach individuals who are unable to attend community planning sessions or who may be unwilling or unable to provide public comment in person at meetings by November 1, 2018.
- Distribute and collect needs assessment surveys by December 31, 2018.
- Complete an annual MHSA assessment of needs by March 30, 2019.
- To follow-up on its CLAS survey with a more robust survey to be administered to all staff, a division-wide and program-specific inventory of Cultural Competency knowledge via the CBMCS to identify gaps in the knowledge base of BHS Staff Members and Partners will be administered to all staff by June 30, 2019.
- Develop strategies and an action plan to address CBMCS findings by June 30, 2019.

Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural and Linguistic Mental Health Disparities

(CLAS Standard 1, 10, 14)

As a result of its 2016-17 MHSA Community Planning Process, BHS developed and implemented a major strategy to reducing racial, ethnic, cultural and linguistic mental health disparities. BHS designed and received approval to create an Assessment and Respite Center in partnership with a local Federally Qualified Health Center (FQHC).

In its planning process, BHS found that many individuals from communities of color were not accessing behavioral health services due to stigma, a lack of culturally competent services, or from prior negative interactions with behavioral health treatment providers.

The new Assessment and Respite Center, which opened in June 2018, is designed as a "friendly front door" to services for individuals who are unlikely to access services from the public behavioral health system. Community Medical Centers (CMC), a local non-profit community health care provider and a Federally Qualified Health Center (FQHC), was selected as the lead project partner because it has a long standing reputation in the community for serving racial and ethnic minorities, having started over forty years ago providing health care services in the fields to migrant farm workers. Over the years it has grown to a network of 12 community clinics serving over 80,000 patients. Ninety-seven percent of patients are low-income and 83% identify as ethnic or racial minorities.

2017-18 Accomplishments

- A MHSA Innovation Project for an Assessment and Respite Center focused on increasing access to behavioral health services for racial and ethnic minorities was developed by BHS and approved by the

County's Board of Supervisors in November 2017 and by the California Mental Health Oversight and Accountability Commission in January 2018.
- The Assessment and Respite Center opened to services in June 2018.

2018-19 Strategies
- Monitor the success of the Assessment and Respite Center by reviewing quarterly data on the demographics of individuals served and qualitative data including consumer satisfaction data, quarterly.
- Implement adjustments to the activities of the Assessment and Respite Center in the annual contract review process by March 30, 2019.
- Dedicate efforts of the BHS Cultural Competency Committee to the development of additional strategies for outreach and engagement to Latino/Hispanic communities by making it a permanent agenda item on monthly meetings beginning January 2018.

Criterion 4: County Mental Health Systems Client/Family Member/Community Committee:

(CLAS Standard 13)

BHS has two avenues to discuss the cultural competence of its staff and services:
- A Cultural Competency Committee comprised of BHS staff, consumers/family members, and other stakeholders.
- The Consortium, established in 2007, comprised of a variety of stakeholders: representatives of community based organizations, consumers and family members, community members and BHS staff.

The Cultural Competency committee was developed in accordance with the requirements of Title IX, CA Code of Regulations, Chap. 11, Article 4 Section 1810.410, (b). BHS policy states that:
1. BHS shall maintain a Cultural Competence Committee that has representation from management staff, direct services staff, consumer, community members and representatives of cultures from the community
2. The Cultural Competence Committee shall meet regularly to review the BHS adherence to the BHS Cultural Competency Plan by reviewing goals and objectives and make appropriate recommendations to BHS Administration regarding management and service provision as it relates to cultural and linguistic services.
3. The Cultural Competence Committee shall elicit, suggest, review, monitor and support strategies to increase penetration and retention rates for identified community groups.
4. The Cultural Competence Committee will collaborate with the MHSA Consortium and organizations representing various groups within the community.

The Consortium meets monthly to discuss community-wide behavioral health services in a framework of cultural diversity. Many meetings include presentations on services for diverse racial and ethnic communities and focus on cultural competence and language proficiency. The Co-Chair of the Cultural Competency Committee is responsible for planning the Consortium activities along with community stakeholders. The Consortium has become a vehicle through which the Cultural Competency Committee informs our stakeholders of continuous Cultural Competency efforts.

2017-18 Accomplishments: The Cultural Competency committee achieved significant successes with the development of three major projects:
- The development of a BHS Cultural Competency Policy (see attachment 2)
- The development of standardized and mandatory online staff training on Cultural Competence (see attachment 1)
- A survey of managers on Culturally and Linguistically Appropriate (CLAS) Standards.

2018-19 Strategies

- Hold at least eight meetings involving representation from management staff, direct services staff, consumer, community members and representatives of cultures from the community by June 30, 2019.
- Elicit, suggest, review, monitor and support at least two new strategies to increase penetration and retention rates for identified community groups by June 30, 2019.
- Collaborate with the Consortium by disseminating Cultural Competency information and strategies at five Consortium meetings by June 30, 2019.
- Recruit and ensure at least two consumers and/ or family members are present at each Cultural Competency Committee meeting.

Criterion 5: County Mental Health Plan Culturally Competent Training Activities

(CLAS Standard 4)

To ensure that the cultural competence training is widely available and to track employee compliance with training participation, BHS developed an online training that will be taken within 12 months of employment and for which participation can be tracked electronically. In addition, BHS will incorporate considerations of culture in systemwide, multidisciplinary trainings related to Medical Necessity and Level of Care

2017-18 Accomplishments:

- Development of an on-line training course in Cultural Competence for all BHS employees (See Attachment 1)
- BHS has also continued its efforts in providing Cultural Competent presentations via the Consortium as outlined in Criterion 4.

2018-19 Strategies:

- Monitor the numbers of staff participating in the online course by June 30, 2019 (Monitoring as of Dec. 31, 2018 completed; reported in QAPI Workplan, FY 18/19, 1/15/19)
- Adjust the online course curriculum in response to feedback from participants and new learning strategies in line with best practices for cultural competency training by June 30, 2019.
- Develop and implement culturally competent Medical Necessity and Level of Care training by June 30, 2019.

Criterion 6: County Mental Health System's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

(CLAS Standard 7)

The BHS Cultural Competency Committee reviewed the San Joaquin County data of its staff collected with an in-house database. The data was provided to the Office of Statewide Health Planning and Development (OSHPD) for inclusion in its Statewide Evaluation/Workforce Education and Training (WET) Workforce Needs Assessment in September 2018. The results of the Statewide Needs Assessment are included in attachment 6. The table below compares proportional data on BHS employees to client data from CALEQRO and the United States Census data:

	BHS staff (Number)	BHS staff %	Medi-Cal Beneficiaries % (CALEQRO)	County % (Census)
Caucasian/White	260	35.5%	18.6%	31.8%
Hispanic	186	25.4%	45.9%	41.6%
Asian	127	17.3%	9.8%	16.7%
Black/African American	86	11.7%	15.1%	8.2%
Other	74	10.0%	10.6%	1.7%
Total	733	100%	100%	100%

Data shows that BHS staff are very underrepresented in staff that are Hispanic and slightly underrepresented in Black/African American staff.

2017-18 Accomplishments

- Maintained an in-house database of staff ethnicities.
- Provided data to OSHPD for inclusion in the 2018 State Evaluation/Workforce Education and Training (WET) Workforce Needs Assessment.
- Reviewed staff data to determine areas in which the BHS staff was over or under-represented.

2018-19 Strategies

- The BHS Cultural Competency Committee will develop strategies for increasing the recruitment of staff from the Latino/Hispanic and Black/African American communities by June 30, 2019.
- The BHS Cultural Competency Committee will provide recommendations for improvement in tracking deficiencies highlighted in the Statewide Evaluation/Workforce Education and Training (WET) Workforce Needs Assessment by June 30, 2019.

Criterion 7: County Mental Health System Language Capacity

(CLAS Standard 5,6,8)

The BHS Cultural Competency Committee reviewed the language capacity of its staff collected with an in-house database. This data was provided to the OSHPD for inclusion in the 2018 State Evaluation/Workforce Education and Training (WET) Workforce Needs Assessment. The data, provided below, shows serious deficiency in staff that speak Cambodian, Vietnamese, and Laotian. Other unrepresented languages are American Sign Language and Korean. BHS's goal is to increase recruitment and retention of linguistically diverse staff to improve staff to beneficiary ratios.

Primary languages spoken by clients and staff	# of Clients	# of BHS Staff Providing Direct Services	Staff to client ratio
English	13,782	705	1:20
Spanish	830	80	1:10
Cambodian	391	4	1:98
Vietnamese	193	0	n/a
Laotian	89	0	n/a
Hmong	78	8	1:10
Tagalog	47	42	1:1
Arabic and Farsi	30	2	1:15
Chinese (Mandarin and Cantonese)	18	1	1:18
American Sign Language	10	0	n/a
Korean	3	0	n/a

2017-18 Accomplishments

- Maintained an in-house database of language capacity of BHS staff.
- Provided data to OSHPD for inclusion in the 2018 State Evaluation/Workforce Education and Training (WET) Workforce Needs Assessment.
- Reviewed staff data to determine areas in which the BHS staff was over or under-represented.

2018-19 Strategies

- The BHS Cultural Competency Committee will develop strategies for increasing the recruitment of staff that speak Cambodian, Vietnamese, and Laotian by June 30, 2019.
- The BHS Cultural Competency Committee will provide recommendations for improvement in tracking deficiencies highlighted in the Statewide Evaluation/Workforce Education and Training (WET) Workforce Needs Assessment by June 30, 2019.

Criterion 8: County Mental Health System Adaptation of Services
(CLAS Standard 12)

The MHSA Annual Update contained a number of new programs and services to be implemented in 2018-19. BHS has included the requirement for cultural and linguistic competence in each of the project descriptions and its Requests for Proposals (RFP). BHS will document the necessity of cultural and linguistic competency in its contractual requirements and will monitor contractors to ensure that services are being implemented accordingly.

2017-18 Accomplishments

- The standard for cultural and linguistic competence in new MHSA projects was documented in the MHSA Annual Update.

2018-19 Strategies

- BHS contracts for new MHSA services will document the requirement for cultural and linguistic competence.
- BHS will monitor contractors to ensure that new services are being implemented with cultural and linguistic competence.

Attachments:

1. BHS Cultural Competency Policy (#0105.0025.0)
2. Online Cultural Competence Training
3. 2018-19 Annual Update to the Three Year Mental Health Services Act Program and Expenditure Plan, pages 6 through 15
4. San Joaquin County-specific Data provided by CALEQRO
5. Training Presentations at Consortium meetings, January 2017 to June 2018
6. Workforce Needs Assessment (Based on state Fiscal Year 2016-17 (July 1st, 2016 – June 30th, 2017)

Attachment 1: BHS Cultural Competency Policy (#0105.0025.0)

San Joaquin County Behavioral Health Services			
BEHAVIORAL HEALTH ADMINISTRATION			
Originating Department: BHS Administration	**Original Issue Date:** 12/18/2017	**Policy Number:** 0105.0025.0	**Page:** 1of3
This Policy Applies To: All BHS Programs	**Revision Date:** **Reviewed Date:**	**Written By:** Angelo Balmaceda, Administrative Assistant II	**Approved By:** Cara Dunn, Deputy Director, Administration Frances Hutchins, Assistant Behavioral Health Director Tony Vartan, LCSW, Behavioral Health Director
SUBJECT: Cultural Competency			
THIS POLICY SUPERSEDES THE FOLLOWING POLICY:			

POLICY
This policy services to comply with the State Department of Health Care Services requirements, Federal and State Laws and to emphasize San Joaquin County Behavioral Health Services' (BHS) commitment to providing culturally and linguistically appropriate services.

PURPOSE
The purpose of this policy is to communicate to BHS staff and contractors the division's commitment to provide cultural and linguistic appropriate services to its clients and consumers via various procedures throughout the department. Additionally, the policy details how BHS will provide planning, implementation, training and oversight via the Cultural Competency Plan, Cultural Competency Training Plan and Cultural Competency Committee to reduce and eliminate cultural, linguistic, racial, and ethnic behavioral health disparities.

DEFINITION
Cultural Competence is a set of congruent practice skill knowledge, behaviors, attitudes and policies that come together in a system, agency, or among consumer providers, family members and professionals that enables the system, agency, or those professionals and consumers, and family member providers to work effectively in cross-cultural situations (adapted from Cross, et al., 1989; cited in DMH Information Notice, 02-03).

COMPLIANCE MONITORING

Cultural Competency activities will be reported to the BHS Quality Improvement Council on a quarterly basis. A summary of activities will include progress on 1) goals and objectives of the Cultural Competency Plan, 2) Cultural Competency training and, 3) Cultural Competency Committee updates.

PROCEDURE

1. Cultural Competency Plan: In accordance with DMH Information Notice Number 10-02: Cultural Competency Plan Requirements and Title IX, California Code of Regulations, Chapter 11, Cultural Competence Plan for Mental Health Plans (MHP), BHS will adhere to the establishment of DHCS mandated Cultural Competency Plan Requirements as follows:
    a. Commitment to Cultural Competence
    b. Updated Assessment of Service Needs
    c. Cultural Competency Advisory Committee
    d. Strategies and efforts for reducing racial, ethnic, cultural and linguistic behavioral health disparities
    e. Client/Family/Family Member/Community Committee: Integration of the Committee within the County behavioral health system.
    f. Culturally competent training activities
    g. County's commitment to growing a multicultural workforce: Hiring and retaining culturally and linguistically competent staff
    h. Language Capacity
    i. Adaptation of Services

2. Cultural Competency Training Plan - BHS Staff at all levels and across all disciplines will receive ongoing education and training in culturally and linguistically appropriate service delivery. [Cultural and Linguistically Appropriate Services Standards, Standard No. 3, DMH Information Notice Number 10-02 and Title IX, CA Code of Regulations,]Chap. 11, Article 4 Section 1810.410, (c)(3)]
    a. All staff will attend and complete Sthe an Joaquin County training entitled, "*Diversity and Inclusion*" every five years.
    b. All staff will complete the online BHS entitled, "*Cultural Competence in County Mental Health*" via the BHS Self-Paced Training platform.
    c. All Staff with client contact will complete the BHS training entitled, "*Limited English Proficiency*".

3. Cultural Competence Committee – BHS will convene a Cultural Competence Committee in accordance with the requirements of Title IX, Californria Code of Regulations, Chapter. 11, Article 4 Section 1810.410, (b):

a. BHS shall maintain a Cultural Competence Committee that has representation from management staff, direct services staff, consumer, community members and representatives of cultures from the community
b. The Cultural Competence Committee shall meet regularly to review the BHS adherence to the BHS Cultural Competency Plan by reviewing goals and objectives and make appropriate recommendations to BHS Administration regarding management and service provision as it relates to cultural and linguistic services.
c. The Cultural Competence Committee shall elicit, suggest, review, monitor and support strategies to increase penetration and retention rates for identified community groups.
d. The Cultural Competence Committee will collaborate with the Mental Health Services Act Consortium and other organizations representing various groups within the community.

Attachment 2 - Online Cultural Competence Training

Intro to Cultural Competence – A Preparedness and Orientation Course
(Online Mandatory Training for ALL Staff)

Summary:
The online training prepares BHS staff as an introductory and orientation course to cultural competence within California's Behavioral Health Organizations

Topics Covered:
- The Rational for cultural competence
- A brief history of cultural competence in mental health
- Defining cultural competence and culturally responsive care
- Components of a culturally competent service organization
- National CLAS Standards
- Cultural Formulation in DSM-5
- Resources

Learning Objectives:
- Increase knowledge of the origin of cultural competence in California.
- Recognize the value of cultural responsive whole healthcare and its impact on positive outcomes.
- Identify indicators for a culturally competent organization.
- Associate general concepts and terms for culturally competence practices.

**Training meets Federal CLAS Standard Requirement (Standard #4)
- Educates and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

**Training meets State Culturally Competency Plan Requirement (Criterion #5)
- Culturally Competent Training Activities – Staff Education and training are crucial to ensuring culturally and linguistically appropriate services. All staff shall receive annual cultural competence training.

Attachment 3: 2018-19 Annual Update to the Three Year Mental Health Services Act Program and Expenditure Plan, pages 6 through 15

Community Program Planning and Stakeholder Process

Community Program Planning Process

The community planning process serves as an opportunity for consumers, family members, mental health and substance abuse service providers and other interested stakeholders to discuss the needs and challenges for consumers receiving mental health services and to reflect upon what is working for the diverse range of consumers served. The following activities were conducted to gather information regarding current services and to provide recommendations on the need for updates and revisions.

Quantitative Analysis:

- BHS Program Service Assessment: December – March
  - Prevention, Early Intervention, Outpatient and Crisis Services Utilization Analysis
  - Penetration and Retention Reports
  - Timeliness Reports
  - Client Satisfaction Report
  - Cost per Person Analysis
- Annual Evaluation of Prevention and Early Intervention Programs for 2016/17

Community Discussions:

- Behavioral Health Board:
  - November Meeting at the Public Library in Lodi
  - February Meeting at BHS in Stockton
  - March Meeting at the Public Library in Tracy
- General Public Forums
  - February 26th at the Public Health Department
  - February 27th at the Robert J. Cabral Agriculture Center
  - March 8th at the Dorothy L. Jones Cuff Center

Key Informant Interviews

- San Joaquin County
  - Monica Nino, County Administrator
  - Supervisor Tom Patti
  - Supervisor Miguel Villapudua
- Community Partners
  - Meetings and program tours with both partner and non-partner community-based organizations throughout San Joaquin County.
- BHS Staff, Deputy Directors, and Clinical Program Managers

Targeted Discussion Groups

- Consumer Focus Groups
  - Wellness Center
  - Martin Gipson Socialization Center
- Potential Partner Discussion Groups
  - Justice Partners (Probation, Local Law Enforcement, Courts, District Attorney, etc.)
  - Schools (San Joaquin County Office of Education and Local School Districts)
  - Child Welfare Services

Program Service Assessment

San Joaquin County Behavioral Health Services (BHS) provides behavioral health services, including mental health and substance use disorder treatments to over 15,900 consumers annually. In general program access is reflective of the diverse population of San Joaquin County; with a roughly even division of male and female clients. A snapshot in time analysis of services provided in March 2018, provides a general overview of program participation.

Mental Health Services provided March 2018

Services provided by Age	Number	% of Total
Children	1243	22.6
Transitional Age Youth	996	18.1
Adults	2634	47.8
Older Adults	634	11.5
Total	**5507**	**100%**

Program participation is reflective of anticipated demand for services, with the majority of services being delivered to adults, ages 25-59 years of age. The participation amongst other age groups is consistent with their percentage within the total population.

Services provided by Race/Ethnicity	Number	% of Total
White	2085	37.9
Latino	1325	24.1
African American	1039	18.9
Asian	558	10.1
Other	258	4.7
Native American	224	4.1
Pacific Islander	18	0.3
Total	**5507**	**100%**

Diversity of participants is similar to the distribution in prior years. African Americans are disproportionately represented amongst consumers compared to their proportion of the general population (19% of participants, though comprising 7% of the population of the County). Latinos are enrolled as lower rates compared to their proportion of the general population (24% of participants while comprising 41% of the population) – though this rate is up slightly from prior years.

Participation amongst children and youth is more reflective of the racial demographics of the overall population, with over a third of services provided to young Latinos (35%), suggesting that while stigma, language or cultural barriers, or access to health care services continue to impeded access for Latino adults with behavioral health needs more services are reaching the younger populations.

Services provided by City/Community	Number	% of Total
Stockton	3851	67.3
Lodi	512	8.9
Other	502	7.9
Tracy	379	6.6
Manteca	365	6.4
French Camp	142	2.5
Lathrop	87	1.5
Total	**5838**	**100%**

The majority of clients are residents of the City of Stockton. Stockton is the County seat and largest city in the region, accounting for 42% of the county population. The majority of services and supports for individuals receiving public support benefits (including mental health) are located in Stockton.

Diagnosis	Number	% of Total
Mood Disorder	1976	34.5
Schizophrenia	1493	26.1
Other	850	14.8
Anxiety Disorder	732	12.8
Adjustment Disorder	493	8.6
Behavioral Disorder	368	6.4
Personality Disorder	4	0.1
Total *Some clients have more than one diagnosis	**5916**	**100%**

Mood disorders and those on the spectrum of schizophrenia disorders are present amongst the majority of clients served. No significant differences are noticeable with regards to how illnesses are distributed by race/ethnicity, though a slightly greater proportion of the individuals diagnosed with schizophrenia are African American (23% of all individuals diagnosed with schizophrenia) likely reflecting the overall overrepresentation of African Americans in treatment services. More men are diagnosed with schizophrenia disorders than women and women are more likely to be diagnosed with mood disorders.

Community and Program Discussions

Findings from Consumer Focus Groups

Consumer focus groups were convened at the following locations:

- Martin Gipson Socialization Center, operated by the University of the Pacific Community Re-Entry Project
- Peer Recovery Services, a consumer operated wellness center

Nearly all consumers participating in the focus group self-identified as having co-occurring mental health and substance use disorders.

The discussions focused on responses to the following questions:

- What aspects of BHS program services are working well for you and supporting you on your recovery journey?
- Are there barriers or challenges that make it difficult for you to meet your recovery goals?

- What was your experience when you first started seeking assistance? Do you have any recommendations on how we can improve access to services?
- Do you have any other recommendations on how BHS can improve services or otherwise support your recovery process?

Overall, consumers who participated in the focus groups reported a strong appreciation of their clinicians and case management who provided services to them on a daily basis. They reported that case planning and one-on-one time with case managers was one of the most beneficial aspects of services and that being able to participate in groups and individual counseling sessions remained among their highest service priorities.

Housing, and the ability to maintain and secure safe and affordable housing, continues to top the list of major consumer concerns. While most of the consumers participating in groups reported having a place to live many were worried about increasing rents. Others (currently or recently homeless) shared troubling stories about their inability to find housing. Rising rents, scarcity of housing, and more stringent application processes seem to be fueling the housing crisis for consumers. Several consumers reported being homeless one or more day in the past six months.

Transportation was also a major concern in both discussion groups; one group reported that bus routes had recently changed impacting access to services. The second group discussed the need for a cross walk between BHS and the bus stop on the adjacent side of the street.

In prior years, consumers reported long wait times to see a psychiatrist. This year there were fewer concerns about wait times for routine psychiatric visits. This is likely reflective of the impact made by the hiring of several new psychiatrist in 2017. However many reported that they have a hard time scheduling next-day appointments when they are feeling unwell. Several recommended being told that they should go to crisis because they couldn't get an appointment for a relatively non-urgent concern within a timely period. In particular consumers report having had trouble understanding how to get the help they feel that they need. Often during the discussion, one consumer would provide a recommendation to another consumer about who to call, what to say, and how to get appropriate services in a timely manner. Not surprisingly, consumers reported a need for more peer navigation services. This recommendation has been included in this Annual Update as a new CSS program.

Finally, consumers reported wanting more in the ways of recreation, socialization, and life skills such as healthy meal preparation and employment training. Consumers also reported concern about accessing primary health care services, including dentistry.

Findings from Potential Partner Focus Groups

Meetings were held with stakeholders and community partners to determine new opportunities to expand and enhance services for individuals with mental illnesses, per San Joaquin County Board of Supervisors directives to expand and enhance collaborative efforts across government and community based partners (Three Year Strategic Priorities). The BHS planning team also met individually and in focus group discussions with community based partners, school personnel, child welfare services, and law enforcement and justice partners. The results from the planning discussions with law enforcement and justice partners, pertaining to non-serious and nonviolent offenders with behavioral health concerns and /or homeless individuals are reported in the section below as an update to the 17/18 planning process. In additional the following key findings and recommendations were determined.

- There remain critical system gaps for children and youth within the dependency system (child welfare and/or juvenile justice system). San Joaquin County does not have enough licensed short term residential therapeutic programs (STRTPs) to meet the local demand for services. As a result children within the child welfare system stay longer than indicated in the emergency children's shelter and, without appropriate level of care interventions, some youth have escalating behaviors that result in a juvenile justice contact.
    - Next Steps for 2018/19: BHS and the San Joaquin County Human Services Agency (HSA) will continue to develop collaborative strategies to address system gap. For the short-term BHS will increase clinical resources to the FSP program serving dependency youth and to the Mary Graham emergency shelter for children. BHS and HSA are also entering into exploratory dialogue regarding to potential to develop a crisis residential treatment program for children and youth.

- School base mental health services are insufficient to meet demand and are implemented with few oversights and varying levels of effectiveness at different schools. The biggest concern was the use of a "pool" of clinicians to work with schools. School personnel reviewed the importance of having dedicated clinical staff working within the school milieu and the importance of services beyond individual counseling for children and youth including life skills and rehabilitation groups to address impulse control, positive peer relationships. Other areas of service support recommended include more participation in student support teams and working collaboratively with school staff to address behavioral concerns that escalate beyond the disciplinary / code of conduct rules and procedures for schools.
    - Next Steps for 2018/19: BHS is ending the Trauma Services for Children and Youth program and creating a new and strengthened PEI program for School-based Interventions for children and youth that will provide early intervention services to elementary, middle, and high school age youth to address a range of behavioral health concerns. School-based Intervention services will be targeted to schools in which a large number of students have a higher than average risk of developing a mental illness. Extreme poverty, and adverse childhood experiences including poverty, are identified in the California Code of Regulations (§3720) as a risk factor for mental illness. School-based Intervention services will prioritize schools in which a substantial majority of students are eligible to participate in the free or reduced price meal program.

- Prevention and Early Intervention Services are primarily directed to children and youth. In prior years, more than 75% of all PEI programming was directed to children and youth. Community stakeholders suggested that more PEI services be directed towards TAY, Adult, and Older Adult populations.
    - Next Steps for 2018/19: BHS will allocate over $3million in PEI funds for early intervention programs for TAY, Adult, and Older Adult populations in FY 2018/19. Services include funding for a new diversion support program; enhanced funding for a clinician to work with adults that have been victims of human trafficking; and a new program that will provide funding to one or more community based partners to provide trauma response services to TAY, Adult, and Older Adults in San Joaquin County. BHS will seek partners that can offer an array of culturally competent services using evidence based practices.

Findings from Discussions with Staff and Partners

Meetings were held with Deputy Directors and clinical program managers from all areas of the BHS service delivery system in January and February of 2018, in order to gain input from clinicians regarding their thoughts on the greatest gaps and challenges in the mental health service delivery system.

Major Concern #1: Inpatient and Residential Services

Inpatient and Residential services are available for consumers with the most acute and chronic care needs. Utilization of inpatient and crisis residential services is high. Bed spaces are typically full in local crisis residential and psychiatric health facilities, sometimes requiring transport out of the county for necessary treatment services.

One challenge is that crisis personnel report having poor discharge options for individuals to step down to less restrictive levels of care because (1) programs are full – there are insufficient care homes to meet demand; or (2) programs feel that client acuity may be too high for the placement. The following have been identified as immediate needs:

- Adult residential facility, for individuals that are eligible to leave crisis residential treatment but do not have a safe and stable place in which to continue their recovery efforts.
- High-risk transition team, for individuals that have had one or more failed transitions from acute care services to routine outpatient services. The Transition Team will provide wrap-around case management while clients are staying in an inpatient hospital, crisis residential facility, or other licensed residential program in order to help facilitate the transition to routine treatment. A project goal is to reduce the number of emergency responses to residential facilities.

BHS also recognizes that some clients with high acuity require a long period of structured recovery. BHS is exploring options to develop a short term acute rehabilitation program. BHS will allocate a portion of CSS funds to the Capital Facilities funds in order to support crisis and acute care expansion project needs. (Pursuant to Welfare and Institutions Code §5892(b) Counties may allocate up to 20% of the total average amount of funds allocated to the County for the previous five years. Funds are distributed between WET, CFTN, and the Prudent Reserve.)

Major concern # 2: FSP Engagement and Service Utilization

Service utilization amongst engaged clients is lower than targeted. Individuals enrolled in FSP programs receive, on average, less than six hours of service utilization each month. Target expectations for FSP program clients is for significantly more contact with clinical and case management staff. BHS continues to review opportunities to strengthen service delivery. Program staff members indicate that some clients require very, very extensive services, reducing time available to spend with clients that have reached more of their recovery goals. As a result, BHS will be making significant changes over the next two years to the full service partnership delivery system.

This Annual Update describes two new programs to support FSP clients that require very intensive services. These shall be developed with contracted Organizational Providers that are identified through a public procurement process. Notice has also been given to existing partners providing FSP Engagement services that current contracts will end June 2019. Community partners are invited to submit applications in response to forthcoming Requests for Proposals or Qualifications (RFPs or RFQs). Most new programs developed through this Annual Update licensed and certified Organizational Providers. Community partners that are not

Organizational Providers can contact CA Community Care Licensing Division for more information on the licensing and certification process.

Updates from 2017/18 Recommendations:

Several findings were made during the prior year's MHSA community program planning process. The section below re-iterates those findings and recommendations and provides an update on the program services or actions that have been taken to address recommendations.

- There are insufficient affordable housing units available to ensure that all mental health consumers have safe and secure housing options.
    - Recommendation: Create new affordable housing solutions, blending funding from multiple sources.
    - Update: BHS created a project based housing fund and is working in partnership with the Housing Authority of San Joaquin County to develop new permanent housing units for people with serious mental illness that have, or are eligible for voucher-based housing (formerly Section 8 housing). Over the next two years BHS and the Housing Authority hope to construct up to 35 new units for people with serious mental illnesses.
    - Update: BHS received approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) in January of 2018, for the implementation of the Progressive Housing Innovation Program. Progressive housing is a shared housing program for formerly homeless individuals with serious mental illness and co-occurring disorders. Progressive Housing offers a tiered approach to housing and recovery services that is designed to support individuals at different stages of the recovery process with the goal of "graduating" participants into independent living programs.

- There are insufficient outreach and engagement staff members conducting "field outreach" with individuals whose symptomology indicates a possible mental health disorder.
    - Recommendation: Reconsider outreach and engagement with a multi-agency approach. Include law enforcement in discussions to enhance local capacity to divert individuals with mental health conditions from the local jail.
    - Update: BHS has been engaged in a planning process with law enforcement and other partners to address diversion opportunities for individuals with mild, moderate, and serious mental illnesses and co-occurring disorders. A collaborative project with joint BHS, District Attorney and Law Enforcement commitments is currently in the planning stages with pilot implementation planned for fall 2018. PEI resources will be allocated to this collaborative endeavor.
    - Update: BHS will also expand Mobile Crisis Support Teams. Two new mobile crisis support teams will join the existing fleet within the next fiscal year. The new teams will be stationed outside of Stockton in the North and South portions of the County.

- The population of homeless individuals with serious mental illness may be higher than anticipated. In the 2017 unsheltered homelessness count, 30% of homeless individuals self-reported a mental health concern.
    - Recommendation: Linkages to mental health services should be developed in tandem with any efforts to increase homeless outreach and engagement. More opportunities should be made available to meet individuals where they are during the assessment process.

- Update: Given the homeless crisis that is currently being experienced BHS is committing more resources and effort to working collaboratively with a range of programs and services. BHS understands that homelessness is a major concern of the community and is shifting the local priorities for FSP enrollment so that experiences of homelessness are of major consideration for FSP enrollment. San Joaquin County has also recently appointed an individual to lead county-wide efforts to address homelessness.

- Individuals with serious mental illnesses continue to have high rates of co-morbid conditions, including co-occurring substance use disorders, high blood pressure, and diabetes. Smoking rates are very high amongst consumers and continue to lead to chronic health conditions.
  - Recommendation: Strengthen partnerships with primary health care services. Create joint training opportunities for psychiatrists and primary care physicians.
  - Update: BHS received approval from the MHSOAC for the creation of the Assessment and Respite Center in partnership with Community Medical Centers (CMC). CMC will operate a drop in facility for individuals with behavioral health concerns to receive assessment and intervention services: respite services, withdrawal management, triage, assessment, and referral to care services. On site staff include medical personnel, clinicians, substance use counselors, case managers, and peer partners. Through the CMC partnership clients will be linked to any needed health, mental health, or substance use disorder treatment services. CMC also offers dentistry, reproductive health, and other specialty health care services.

Attachment 4: San Joaquin County-specific Data provided by CALEQRO

Table 1: San Joaquin MHP Medi-Cal Enrollees and Beneficiaries Served in CY16, by Race/Ethnicity				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count of Beneficiaries Served**	**% Served**
White	56,169	18.6%	3,602	29.5%
Latino/Hispanic	138,697	45.9%	3,514	28.8%
African-American	29,735	9.8%	1,945	15.9%
Asian/Pacific Islander	45,758	15.1%	1,278	10.5%
Native American	822	0.3%	67	0.5%
Other	31,149	10.3%	1,792	14.7%
Total	**302,327**	**100%**	**12,198**	**100%**

	SAN JOAQUIN					MEDIUM		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL	302,327	12,198	$48,619,931	4.03%	$3,986	4.07%	$5,916	4.44%	$5,746
AGE GROUP									
0-5	41,012	443	$1,487,709	1.08%	$3,358	1.50%	$4,070	2.04%	$4,842
6-17	80,725	3,190	$13,642,349	3.95%	$4,277	5.00%	$6,796	6.01%	$7,222
18-59	149,520	7,485	$29,817,540	5.01%	$3,984	4.50%	$5,609	4.70%	$5,110
60 +	31,072	1,080	$3,672,333	3.48%	$3,400	3.03%	$5,681	2.75%	$4,577
GENDER									
Female	161,057	6,330	$23,814,803	3.93%	$3,762	3.79%	$5,737	4.07%	$5,333
Male	141,271	5,868	$24,805,128	4.15%	$4,227	4.40%	$6,091	4.87%	$6,145
RACE/ETHNICITY									
White	56,169	3,602	$13,549,213	6.41%	$3,762	5.69%	$5,936	6.01%	$5,372
Hispanic	138,697	3,514	$12,500,137	2.53%	$3,557	2.74%	$5,279	3.38%	$5,430
African-American	29,735	1,945	$8,268,540	6.54%	$4,251	6.48%	$5,843	7.76%	$6,158
Asian/Pacific Islander	45,758	1,278	$4,874,061	2.79%	$3,814	2.35%	$5,276	2.25%	$5,728
Native American	822	67	$241,829	8.15%	$3,609	6.41%	$5,714	7.38%	$5,805
Other	31,149	1,792	$9,186,151	5.75%	$5,126	6.31%	$7,454	6.23%	$6,756

Attachment 5: Training Presentations at Consortium meetings, January 2017 to June 2018

Date	CBO/BHS Program	Title/Subject	Presenter
1/4/2017	VIVO (Vietnamese Volunteer Foundation)	Vietnamese Culture and Healing Process	VIVO, Tham Le
2/1/2017	Power and Support (Consumer Lead Empowerment Group)	San Joaquin County 211	Power and Support Team
3/1/2017	Women's Center of San Joaquin	Presentation of Services	April Lynn
4/5/2017	Community Partnership for Families	Presentation of Services	Sallee Her
6/7/2017	Wellness Center	Peer Recovery Services	Michael Fields
7/5/2017	Disability Resource Agency for Independent Living (DRAIL)	Work Incentive Planning and Assistance	Alexandra Queen
8/2/2017	Child Abuse Prevention Council	Presentation of Services	Shauna Buzunis-Jacob
9/6/2017	TeleCare Corp.	Telecare Early Intervention and Recovery (TEIR)	Melissa Planas
10/4/2017	BHS Prevention Services	Red Ribbon Week Presentation	Prevention Staff
11/1/2017	Parents by Choice	Presentation of Services	Tony Yadon, Joseph Thomas
1/3/2018	Catholic Charities	Presentation of Services	Elvira Ramirez
3/7/2018	SJC Whole Person Care	Program Presentation	Billy Olpin, Amy Smith
4/4/2018	Journey in MH and Wellness	Michael's Journey in Mental Illness and Wellness	Michael Fields, Wellness Center
5/5/2018	Valley Mountain Regional Center	Presentation of Services	Carlos Hernandez
6/6/2018	BHS Homeless Outreach Program	Program Presentation	Billy Olpin, Amy Smith

Attachment 6: Workforce Needs Assessment (Based on state Fiscal Year 2016-17 (July 1st, 2016 – June 30th, 2017)

Number of PMHS employees and vacancies of your agency in this county/city jurisdiction.	
Total Number of Current PMHS Employees	738
Total Number of PMHS Vacancies	131
Total Number of Current **PMHS Direct Service Filled Positions**	485
Total Number of Current **PMHS Direct Service Vacancies**	106

	Filled Positions	**Vacancies**	**Substitute Professions**
Case Manager	85	13	Mental Health Specialists I, II, III
Executive and Management Staff	49	3	
Licensed Clinical Psychologist	0	0	
Licensed Clinical Social Worker	20	6	Mental Health Clinicians II, III
Licensed Marriage and Family Therapist	32	9	Mental Health Clinicians II, III
Licensed Professional Clinical Counselor	1	0	Mental Health Clinicians III
Licensed Psychiatric Technician	58	15	
Occupational Therapist	7	1	Rehab Therapist, Psych Rehab Therapy Assistant
Physician Assistant	0	0	
Psychiatric Mental Health Clinical Nurse Specialist	24	4	
Psychiatric Mental Health Nurse Practitioner	1	3	
Psychiatrist - Child and Adolescent	3	3	
Psychiatrist - General	11	9	
Psychiatrist - Geriatric	2	0	
Substance Abuse/AOD/SUD Counselor	71	15	
Other, please specify: Pharmacy	19	1	
Other, please specify: Non licensed clinicians	59	11	Mental Health Clinicians I
Other, please specify:			

Number of staff in FY 2016-17 by race/ethnicity	**Caucasian/ White**	**Hispanic**	**Middle Eastern**	**Asian**	**Black/ African American**	**Other/ Unknown**
Staff	260	186	0	127	86	74

Estimated number of *clients* who are LGBQIA (lesbian, gay, bisexual, queer, intersex, and asexual)?	Not available
Estimated number of *staff* who are LGBQIA (lesbian, gay, bisexual, queer, intersex, and asexual)?	Not available

Please briefly describe any challenges you have recruiting and/or retaining mental/behavioral health staff to serve LGBQIA populations.
N/A

Does your agency employ Peer Personnel, Peer Specialists, and/or related professions in state FY 2016-17? (Y/N)	Y

If yes:	
Number employed	41
Number vacancies	13

On average, how much time did your peer personnel/peer specialists spend on the following? The total must add up to 100%.	
Case Management	10
Client Support	85
Family Support	5
Clerical Work	
Other, please specify:	

What are the benefits in employing Peer Personnel, Peer Specialists, and/or related professions to your agency/clients?
Relatability to clients

Three-Year Prevention and Early Intervention Evaluation Report

San Joaquin County Behavioral Health Services

Prepared April 2019 for Fiscal Year 2016-17 & Fiscal Year 2017-18

San Joaquin County Behavioral Health Services
Three-Year Prevention and Early Intervention Evaluation Report

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Introduction

In October 2015 the State of California Office of Administrative Law (OAL) approved new MHSA Prevention and Early Intervention (PEI) regulations[1]. The regulations were amended in July of 2018[2]. Under these regulations, San Joaquin County (SJCBHS) must submit a Three Year Prevention and Early Intervention Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC) every three years. The first three-year evaluation must be submitted no later than June 30, 2019. The three-year report includes findings from Fiscal Years 2016-17 and 2017-18 only, since data from Fiscal Year 2015-16 were not required, and thus not available.

For this report, SJCBHS's PEI Projects are classified into specific *Program and Strategy* categories per state regulation. Each of these *Program and Strategy* categories has a specific set of reporting requirements. This report includes a chapter for each BHS PEI project, with a brief description of the project, and two years of required data associated with the project's designated *Program and Strategy* category. The following table distributes SJCBHS's PEI Projects into these *Program and Strategy* categories:

[1] *(CCR, Title 9, 3200.245, 3200.246, 3510.010, 3560, 3560.010, 3560.020, 3700, 3701, 3705, 3706, 3710, 3717, 3720, 3725, 3726, 3730, 3735, 3740, 3745, 3750, 3755, 3755.010),*
[2] A copy of the amended regulations may be found at mhsoac.ca.gov/document/2016-03/pei-regulations

San Joanquin County Projects	PEI Defined Program	Strategies			
		Access & Linkage to Treatment	Timely access to Services for Underserved Populations	Non-Stigmatizing & Non-Descriminatory	Outreach for Increasing Recognition
Skillbuilding for Parents and Guardians	Prevention (3720)	x	x	x	
Mentoring for Transitional Age Youth	Prevention (3720)	x	x	x	
Coping and Resilience Education Services	Prevention (3720)	x	x	x	
Trauma Services for Children Program	Early Intervention (3710)	x	x	x	
Early Interventions to Treat Psychosis	Early Intervention (3710)	x	x	x	x
Family Therapy for Children and Youth	Early Intervention (3710)	x	x	x	
Recovery Services for Victims of Human Trafficking	Early Intervention (3710)	x	x	x	
Early Mental Health Support Services for High Risk Youth at the Juvenile Justice Center	Prevention (3720) Early Intervention (3710)	x	x	x	
Community Trainings - 1	Stigma and Discrimination Reduction Program (3725)	x	x		x
Community Trainings - 2	Outreach for Increasing Recognition (3715)	x	x	x	
CAPC Suicide Prevention	Suicide Prevention (3730)	x	x	x	x

Additionally, this report includes several evaluative features not required by State regulation—namely:

- A breakdown of data for each community-based provider within each PEI Project;
- A comparative assessment of performance across providers; an analysis of dosage (i.e., how much services are provided per recipient); and
- A cost benefit analysis that describes cost per individual served, cost per individual completing/graduating from the program, and/or cost per individual

who demonstrated reduction in risk factors or symptoms or improvement in behavior, knowledge or attitude about mental health.[3]

Prevention Programs[4]

Skill Building for Parents and Guardians

Project Description

Community-based organizations facilitate evidence-based parenting classes throughout San Joaquin County with the goal of reducing risk factors for mental illness and increasing protective factors associated with social connectedness, parent and family resilience, and knowledge of child development.

In Fiscal Years 2016/17 and 2017/18, the Skill Building for Parents and Guardian Project was delivered by four community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC) and Community Partnership for Families of San Joaquin County (CPFSJ) delivered Parent Café groups. *Parent Cafés* derive from the Strengthening Families Initiative, and focus on building 5 research-based protective factors that mitigate the negative impacts of trauma.

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[4] Prevention Programs are a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The purpose of prevention programs is to bring about mental health, including a reduction in applicable negative outcomes, for individuals whose risk of developing a mental illness is greater than average. Examples of risk factors include, but are not limited to adverse childhood experience, chronic medical conditions, experience of severe trauma or ongoing stress, poverty, family conflict or domestic violence, etc. (California Code of Regulations § 3720). Programs shall emphasize strategies to reduce negative outcomes that may result from untreated mental illness, including:

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

(Welfare and Institutions Code § 5840)

- Catholic Charities Diocese of Stockton provided Nurturing Parenting Program (NPP) groups, a series of 10-12 independent 60-90 minute lessons designed to teach parents alternatives to physical punishment and improve parenting skills.
- Parents by Choice (PBC) provided Positive Parenting Program (Triple P) groups. Triple P is an evidence-based, 12-hour program, delivered in six 2-hour group meetings with between 8 and 12 parents. Triple P teaches parents skills to reduce parental stress and increase confidence in parenting in order to prevent behavioral, emotional and developmental problems in children.

Project Outputs

The following table shows the number of parents/guardians directly served and the number of children indirectly served by each provider over the two-year reporting period. The table also includes the number of parenting groups delivered, number of sessions delivered, group size, and service dosage.

Over a two-year period, four community-based organizations delivered 313 distinct parenting classes to 4217 parents/guardians with 5625 children. Each group had on average 14 participants and delivered an average of 8 sessions. Participants, on average, attended 5 (60%) of the offered sessions.

By comparison, CAPC served the greatest number of parents/guardians (1525), whereas CPFSJ served the fewest (731); likewise, CAPC provided the most sessions (1065) whereas CPFSJ provided less than half (436). Participants of Catholic Charities NPP program received the greatest dosage of services (6.1 sessions per participant) whereas CPFSJ received the fewest (3.2 sessions).

Skillbuilding Output	FY 2016/17 and FY 2017/18				Total
	CAPC-PC	CC-NPP	PBC	CPF-PC	
Unduplicated parent/guardian participants	1528	959	998	732	4217
Total children of participants ages 0-25 (reported)	1364	1888	1250	1123	5625
Total number of groups delivered	87	41	96	89	313
Total number of sessions delivered	1065	478	574	436	2553
Average number of participants per group (group size)	17.6	23.4	10.4	8.2	13.5
Average number of sessions delivered per group (dosage offered)	12.2	11.7	6.0	4.9	8.2
Average number of sessions attended per participant (dosage received)	5.2	6.1	5.4	3.2	4.9

Participant Demographics

Demographic information over the two-year period was collected from 3591 out of the 4217 participants (85%). Of these participants, 75% were between the ages of 26-59, slightly more than half (52%) identified as Mexican or Mexican-American, and 39% reported Spanish as their primary language. Two-thirds (66%) identified as female, 63% identified as heterosexual or straight and 28% declined to answer[5], 1.6% reported being a veteran , and more than half (53%) lived in Stockton.

[5] It is the evaluator's belief that several of the programs declined to ask sexual orientation and gender identify questions in accordance with SJCBHS's policy, and additional effort will be made to train programs to collect reliable data in subsequent years.

Skillbuilding Demographics	All Skillbuilding FY 2016/17		All Skillbuilding FY 2017/18		Total	
Unduplicated individuals served	1928		2289		4217	
Number of demographic forms collected	1617	84%	1974	86%	3591	85%
Ages						
0-15	0	0.0%	3	0.2%	3	0.1%
16-25	120	7%	107	5%	227	6%
26-59	1182	73%	1507	76%	2689	75%
60+	113	7%	92	5%	205	6%
Decline to answer	202	12%	264	13%	466	13%
Number of children <26 of participants	2399	n/a	3226	n/a	5625	n/a
Race						
American Indian or Alaskan Native	59	4%	48	2.4%	107	3%
Asian	74	5%	63	3%	137	4%
Black or African American	141	9%	158	8%	299	9%
Native Hawaiian or other Pacific Islander	16	1.0%	18	0.9%	34	0.9%
White	314	19%	452	23%	766	21%
Other	626	39%	726	37%	1352	38%
More than one race	47	3%	59	3%	106	3%
Decline to answer	340	21%	450	23%	790	22%
Ethnicity						
Hispanic or Latino as follows:						
Caribbean	0	0%	0	0%	0	0%
Central America	6	0.4%	15	0.8%	21	0.6%
Mexican/Mexican-American	888	55%	984	50%	1872	52%
Puerto Rican	0	0%	1	0.1%	1	0.0%
South American	2	0.1%	4	0.2%	6	0.2%
Other	4	0.2%	23	1.2%	27	0.8%
Non-Hispanic as follows:						
African	81	5%	149	8%	230	6%
Asian Indian/South Asian	11	0.7%	29	1.5%	40	1.1%
Cambodian	7	0.4%	22	1.1%	29	0.8%
Chinese	1	0.1%	1	0%	2	0.1%
Eastern European	1	0.1%	0	0%	1	0.0%
European	116	7%	150	8%	266	7%
Filipino	33	2%	30	2%	63	1.8%
Japanese	0	0%	0	0%	0	0%
Korean	0	0%	0	0%	0	0%
Middle Eastern	3	0.2%	3	0.2%	6	0.2%
Vietnamese	1	0.1%	0	0%	1	0.0%
Other	69	4%	81	4%	150	4%
More than one ethnicity	64	4%	50	3%	114	3%
Decline to answer	330	20%	289	15%	619	17%
Primary Language						
English	613	38%	650	33%	1263	35%
Spanish	778	48%	1034	52%	1812	50%
Other	32	2.0%	28	1.4%	60	1.7%
Decline to answer	194	12%	261	13%	455	13%

Sexual Orientation						
Gay or Lesbian	13	0.8%	23	1.2%	36	1.0%
Heterosexual or Straight	1107	68%	1162	59%	2269	63%
Bisexual	1	0.1%	4	0%	5	0.1%
Questioning or unsure	0	0%	0	0%	0	0%
Queer	4	0.2%	1	0.1%	5	0.1%
Another sexual orientation	2	0.1%	2	0.1%	4	0.1%
Did not collect	3	0.2%	252	13%	255	7%
Decline to answer	490	30%	523	26%	1013	28%
Disability						
Communication - difficulty seeing	10	0.6%	36	1.8%	46	1.3%
Communication - difficulty hearing & s	2	0.1%	20	1.0%	22	0.6%
Communication - other	0	0%	0	0%	0	0%
Mental disability	13	0.8%	8	0.4%	21	0.6%
Physical/mobility disability	22	1.4%	28	1.4%	50	1.4%
Chronic health	9	0.6%	25	1.3%	34	0.9%
Other	8	0.5%	8	0.4%	16	0.4%
Did not collect	0	0%	252	13%	252	7%
Decline to answer	466	29%	432	22%	898	25%
Veteran status						
Yes	29	1.8%	30	1.5%	59	1.6%
No	1240	77%	1392	71%	2632	73%
Did not collect	0	0%	251	13%	251	7%
Decline to answer	348	22%	278	14%	626	17%
Gender assigned at birth						
Male	246	15%	270	14%	516	14%
Female	1166	72%	1461	74%	2627	73%
Decline to answer	205	13%	243	12%	448	12%
Current Gender identity						
Male	244	15%	247	13%	491	14%
Female	1136	70%	1238	63%	2374	66%
Transgender	0	0%	1	0.1%	1	0.0%
Genderqueer	0	0%	0	0%	0	0%
Questioning or unsure of gender ident	0	0%	1	0.1%	1	0.0%
Another gender identity	0	0%	0	0%	0	0%
Did not collect	0	0%	252	13%	252	7%
Decline to answer	237	15%	235	12%	472	13%
Residence						
Stockton	896	55%	1018	52%	1914	53%
Lodi	172	11%	255	13%	427	12%
Manteca	111	7%	140	7%	251	7%
Tracy	128	8%	143	7%	271	8%
Other	96	6%	157	8%	253	7%
Decline to answer	214	13%	239	12%	453	13%

Participant Outcomes

The following tables show the selected outcome measurement tools, the frequency of administration, and graduation expectation for each provider. The tables also show number of participants who graduated, number who showed improvement in various risk/protective factor domains, and the average number who showed improvement across all domains. Outcomes are shown for each fiscal year and for the two fiscal years combined.

Outcomes for Child Abuse Prevention Council – Parent Cafes

CAPC's Parent Cafes consist of 15 sessions. To graduate, participants must compete 50% of the sessions. Over the 2-year reporting period, of the 1528 program participants, 587 (38%) graduated. Of those who graduated, 91% showed improvement in total scores on the Protective Factor Survey. Participants were most likely to show improvement in their knowledge of parenting skills and least likely to show improvement in social connectedness.

Outcomes: Child Abuse Prevention Council - Parent Cafés						
Instrument: Protective Factors Survey **Freq. of admin:** First and last session **Graduation expectation:** 50% of 15 sessions	2016/17		2017/18		Total	
Unduplicated individuals served	771		757		1528	
Number of graduates	282	*37%*	305	*40%*	587	*38%*
Number of graduates w/ matched pre/post	282	*100%*	305	*100%*	587	*100%*
Number who showed improvement in:						
Knowledge of parenting skills	279	*99%*	276	*90%*	555	*95%*
Access to support	282	*100%*	270	*89%*	552	*94%*
Parental resiliency	277	*98%*	259	*85%*	536	*91%*
Social connections	280	*99%*	227	*74%*	507	*86%*
Parent/child relationships	280	*99%*	242	*79%*	522	*89%*
Total participants who showed improvement*	280	*99%*	255	*84%*	535	*91%*

* Based on average number who showed improvement across all domains

Outcomes for Catholic Charities – Nurturing Parents Program

Catholic Charities requires participants to attend 7 sessions to graduate, Of the 959 program participants, 548 (57%) graduated. Of those who graduated, 72% showed improvement in total scores on the Adult Adolescent Parenting Inventory (AAPI). Participants were most likely to show improvement in levels of empathy and least likely to show improvements in empowering and promoting independence.

Outcomes: Catholic Charities - Nurturing Parents Program						
Instrument: Adult Adolescent Parenting Inventory (AAPI)						
Freq. of admin: First and last session						
Graduation expectation: 6 sessions	2016/17		2017/18		Total	
Unduplicated individuals served	395		564		959	
Number of graduates	219	55%	329	58%	548	57%
Number of graduates w/ matched pre/post	214	98%	248	75%	462	84%
Number who showed improvements in:						
Inappropriate expectations	164	77%	164	66%	328	71%
Low level of empathy	189	88%	211	85%	400	87%
Belief in corporeal punishment	185	86%	190	77%	375	81%
Reverse family roles	153	71%	137	55%	290	63%
Restricts power and independence	142	66%	121	49%	263	57%
Total partcipants who showed improvement*	167	78%	165	66%	331	72%

* Based on average number who showed improvement across all domains

Outcomes for Parents by Choice – Triple P

PBC's Triple P classes involve 8 sessions. To graduate, participants must compete 80% of the sessions. Of the 998 program participants, 803 (80%) graduated. Of those who graduated from one of three different Triple P curriculums, 629 (78%) showed improvement in overall scores. The standard Triple P curriculum showed the greatest improvement among participants (83%) whereas the Family Transitions program showed the lowest improvement among participants (65%).

Outcomes: Parents by Choice - Triple P						
Instruments for regular Triple P classes: Parenting Tasks Checklist (PTC) & Parenting Scale (PS)						
Instruments for Parents of Teen classes: Conflict Behavior Questionnaire (CBQ) & Parenting Scale (PS)						
Family Transitions: Acrimony Scale & Depression Anxiety Stress Scale (DASS)						
Freq. of admin: First and last session						
Graduation expectation: 80% of six sessions	2016/17		2017/18		Total	
Unduplicated individuals served	428		570		998	
Number of graduates	328	77%	475	83%	803	80%
Number of graduates w/ matched pre/post	328	100%	475	100%	803	100%
Triple P Regular	282	86%	215	45%	497	62%
Triple P for Parents of Teens	46	14%	58	12%	104	13%
Family Transitions	n/a		202	94%	202	41%
Number (regular participants) who showed improvement in:						
Setting self-efficacy (PTC)	251	89%	168	78%	419	84%
Behavioral self-efficacy (PTC)	245	87%	169	79%	414	83%
Laxness and Overreactivity (PS)	244	87%	165	77%	409	82%
Total partcipants who showed improvement*	247	87%	167	78%	414	83%
Number (parents of teens) who showed improvement in						
Conflict behavior (CBQ)	38	83%	44	76%	82	79%
Laxness (PS)	37	80%	49	84%	86	83%
Overreactivity (PS)	34	74%	49	84%	83	80%
Total partcipants who showed improvements*	36	79%	47	81%	84	80%
Number (Family Transitions) who showed improvement in						
Acrimony Scale	n/a		133	66%	133	66%
DASS (Depression, Anxiety, Stress) Scale	n/a		128	63%	128	63%
Total partcipants who showed overall improvements*	n/a		131	65%	131	65%
Total participants for all programs who showed overall improvement*	283	86%	345	73%	629	78%

* Based on average number who showed improvement across all domains

Outcomes for Community Partnership for Families – Parent Cafes

To graduate, participants must complete 3 CPF's Parent Cafes sessions. Of the 732 program participants, 234 (32%) graduated. Of those who graduated, 42% showed improvement in total scores on the Protective Factor Survey. Participants were most

likely to show improvement in their knowledge of parenting skills and least likely to show improvement in access to support.

Outcomes: Community Partnership for Families - Parent Cafés						
Instrument: Protective Factors Survey Freq. of admin: First and last session Graduation expectation: 3 sessions	2016/17		2017/18		Total	
Unduplicated individuals served	334		398		732	
Number of graduates	135	*40%*	99	*25%*	234	*32%*
Number of graduates w/ matched pre/post	135	*100%*	99	*100%*	234	*100%*
Number who showed improvement in:						
Knowledge of parenting skills	64	*47%*	44	*44%*	108	*46%*
Access to support	32	*24%*	45	*45%*	77	*33%*
Parental resiliency	55	*41%*	56	*57%*	111	*47%*
Social connections	49	*36%*	48	*48%*	97	*41%*
Parent/child relationships	58	*43%*	40	*40%*	98	*42%*
Child social/emotional competency	67	*50%*	34	*34%*	101	*43%*
Total partcipants who showed improvement*	54	*40%*	45	*45%*	99	*42%*

* Based on average number who showed improvement across all domains

Cost/Benefit Analysis

The following table shows the return on investment for each provider and for the Skill Building Project as a whole, including: costs of the project (represented by amount invoiced), cost per participant, cost per graduate, and cost per individual who showed reduced risk factors and/or increased protective factors.

Skill Building Cost/Benefit	FY 2016/17 and FY 2017/18				All Skillbuilding*		Total*
	CAPC-PC	CC-NPP	PBC-PPP	CPF-PC	2016/17*	2017/18*	
Program Costs	$284,179	$231,737	$291,604	$295,167	$645,202	$642,081	$1,287,283
Unduplicated individuals served	1528	959	998	732	1928	2289	4217
Cost per individual served	*$764*	*$242*	*$292*	*$403*	*$335*	*$281*	*$305*
Number who graduated	587	548	803	234	964	1208	2172
Cost per graduate	*$484*	*$423*	*$363*	*$1,261*	*$669*	*$532*	*$593*
Number who showed improvement	535	332	592	99	747	810	1557
Cost per individual who showed improvement	*$532*	*$699*	*$493*	*$2,976*	*$863*	*$793*	*$827*

*Total includes administrative costs not allocated to programs

Community Based Organization Comparative Analysis

- CAPC offered the most group sessions and served the greatest number of participants but had one of the lowest graduation rates. This was in part because they had the highest graduation expectation (50% of 15 sessions). For those who did graduate and complete a pre post survey, 91% showed increased protective factors. Their cost per participant was the lowest of all four programs, and the cost per graduate and cost per individual who showed improvement was lower than average.

- Catholic Charities provided the fewest groups, and had the largest class size. However, their participants on average attended the greatest number of sessions, suggesting high levels of satisfaction. Because graduation expectation was high (7 sessions) graduation rates were relatively low (57%). Among those who did graduate, 72% showed reduced risk factors. Cost per graduate was the second lowest but cost per individual who showed improvement was the second highest of all 4 programs.

- PBC served the second highest number of participants and provided the most groups. The group size was relatively small (~10 participants) and on average participants attended a relatively high number of sessions. Graduation expectations were slightly lower than two other providers, and by far the provider achieved the highest graduation rate (80%). Seventy-eight percent (78%) of participants showed reduced risk factors/increased protective factors. Cost per graduate and cost per individual who showed improvement was the lowest of any provider.

- CPF served the fewest number of individuals and provided the fewest number of sessions. Participants attended the fewest number of sessions on average. Graduation rates were lower than average (32%) in spite of low expectations (3 sessions). At program conclusion only 42% of participants showed increased protective factors. The cost per graduate was more than double that of other providers, and the cost per individual who showed improvement was more than three times higher than the average across all four providers.

Access and Linkage to Treatment Strategy

In Fiscal Year 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early Fiscal Year 2016/17, SJCBHS and PEI contractors developed more comprehensive referral tracking policies, procedures, and data systems, and, in the 4th quarter of that year, began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs. Detailed data on referrals, including demographic information, are provided to MHSOAC in a secure confidential file. The following is a summary of data on referrals from the Parents/Guardians Skill Building Project.

- In the 4th quarter of the fiscal year 2016/17, a total of 8 individuals identified by the Skill Building Project were referred to SJCBHS for screening and assessment and to determine eligibility for treatment.

- None of these individuals in Fiscal Year 2016/17 engaged in treatment, as defined by participating at least once in treatment.

- During Fiscal Year 2017/18, the Skill Building for Parents/Guardians Project made 8 referrals to mental health treatment.

- One of these individuals engaged in treatment, as defined by participating at least once in treatment.

- Due to the small sample, demographic information on referrals is included in the confidential supplemental file.

Timely Access to Services for Underserved Populations Strategy

San Joaquin County has identified the following underserved populations. In some instances, these populations are referred to treatment, but less so to prevention and early intervention. Underrepresented populations in San Joaquin County include: (a) Hispanic/Latino; (b) Asian; (c) Black/African American; (d) American Indian; (e) Transitional Age Youth; (f) Older Adult; (g) Homeless; (h) Veterans; (i) LGBTQ: (j) Non-English speaking.

The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- In the fourth quarter of Fiscal Year 2016/17, a total of three referrals were made for members of underserved populations (one of the three referred individuals met the criteria for underserved population in two demographic categories).

- None of the 2016/17 individuals participated in the services to which they were referred.

- In Fiscal Year 2017/18 a total of 8 referrals were made for members of underserved populations (7 referred individuals met the criteria for underserved population in two demographic categories).

- One of the individuals participated in the services to which they were referred.

Encouraging Access to Services and Follow Through
The following are ways in which SJCBHS and the Skill Building Project encourage access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- Participants of *Catholic Charities' NPP Program* (predominantly Latino/Hispanic) are encouraged to find professional help for mental health when needed for themselves and other members of their family. Staff of the NPP program reach out to members of the community who do not attend NPP classes. A follow up call is made to every client who has been referred to treatment. Participants are referred to other services or agencies when they fail to receive the mental health services to which they are referred.

- *CAPC's Parent Café* encourages access to services by first making the services in the community known to program participants. There is a section in the Parent

Cafe curriculum dedicated solely to community resources (*Concrete Support for Parents, We All Need Help Sometimes),* in which parents are provided with resource lists from CAPC and San Joaquin County as a whole. CAPC's Parent Café staff also make it a point to let participants know on the first day of the program that they are in a safe place, and what is discussed in the group remains confidential so there is a sense of trust and morale within the group. The participants are encouraged to come to staff if they need any help for themselves or their children. Usually Parent Cafe staff refers participants to CAPC's Family Intervention Program and from there they are linked to SJCBHS mental health services or other community based services. Staff in both programs will then follow-up to discuss a participant's progress and the outcome of treatment.

- *Parents by Choice* staff members emphasize referrals to SJCBHS and other providers. The program has invited other programs to attend team meetings to discuss their programs and how Triple P clients might benefit from referrals.

- All *Community Partnership for Families Parent Cafe* participants complete an intake Welcome Form (WF) that allows staff to assess the family's immediate needs and long-term goals. Based on the assessment, staff members connect participants and their families to both internal CPF services and external services, and follow through with families throughout their enrollment in the program. Some "external referrals" such as WorkNet, Public Health, WIC, CHD, Catholic Charities and CMC are located at CPF Family Resource Center locations, allowing for a seamless handoff and collaborative case management. CPF's case management model includes home visitation and weekly meetings.

Mentoring for Transitional Age Youth

Project Description

Community-based organization provide intensive mentoring and support to transition-age youth (16-25) with emotional and behavioral difficulties who do not meet the criteria for specialty mental health care. The project targets very high-risk youth to

reduce the risk of developing serious and persistent mental illnesses, which are associated with adverse childhood experiences, severe trauma or ongoing stress, family or domestic violence, and/or self-harm or suicidal thoughts.

The Mentoring for Transitional Age Youth (TAY Mentoring) Project was delivered by two community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC); and
- Women's Center Youth and Family Services of San Joaquin County (Women's Center).

Both providers used the Transition to Independence (TIP) service model. TIP is an evidence-based practice designed to engage youth with emotional and/or behavioral difficulties in making a successful transition to adulthood. TIP programs provide case management services and supports to engage youth in activities to help resolve past traumas and achieve personal goals.

Project Outputs

In Fiscal Year 2016/17, the TAY Mentoring Project served a total of 419 individuals, and in Fiscal Year 2017/18, the TAY Mentoring Project served a total of 400 individuals[6]. The following table shows the number of youth directly served by each provider over the two year period. The table also includes two TIP model fidelity scores: the Organizational Survey fidelity scores, rated by program managers, are a composite of 9 items related to staffing, services, supervision and other system-level items; and the TIP Practice Probes are a composite of the scores of three interview questions posed to program staff related to their knowledge and practices. Programs are expected to meet a score of 80% for each fidelity measure.

TAY Mentoring Outputs: FY 2016/17 and F 2017/18	CAPC-TIP	Women's-TIP	Total
Unduplicated individuals served	471	348	**819**
Number of sessions delivered	1900	2938	**4838**
Average number of sessions delivered per individual	4.0	8.4	**5.9**
Organizational Survey fidelity scores (average)	80%	87%	**83%**
TIP Practice Probes fidelity scores (average)	82%	89%	**85%**

[6] To avoid duplication, wo-year total does not include participants who rolled over from FY2016/17 to FY2017/18.

Participant Demographics

Demographics are reported for each year and across the 2-year reporting period for the project as a whole. All participants were age 16-25. They were most likely to identify as Hispanic/Latino (56%) or Black or African American (26%). Ten percent of participants spoke Spanish as their primary language. More than half (54%) identified as female; 82% percent identified as heterosexual and 11% as LGBTQ. A large majority (88%) were Stockton residents.

TAY Demographics FY 2016/17 and FY 2017/18	2016/17		2017/18		Total	
Unduplicated individuals served	419		400		819	
Number of demographic forms collected	419	100%	400	100%	819	100%
Ages						
0-15	0	0%	0	0%	0	0%
16-25	419	100%	400	100%	819	100%
26-59	0	0%	0	0%	0	0%
60+	0	0%	0	0%	0	0%
Decline to answer	0	0%	0	0%	0	0%
Number of children <26 of participants	n/a	n/a	67	17%	67	8%
Race						
American Indian or Alaskan Native	16	4%	8	2.0%	24	3%
Asian	14	3%	8	2.0%	22	3%
Black or African American	103	25%	109	27%	212	26%
Native Hawaiian or other Pacific Islander	7	1.7%	5	1.3%	12	1%
White	64	15%	65	16%	129	16%
Other	85	20%	123	31%	208	25%
More than one race	64	15%	61	15%	125	15%
Decline to answer	66	16%	21	5%	87	11%
Ethnicity						
Hispanic or Latino as follows:						
Caribbean	3	0.7%	0	0%	3	0.4%
Central America	3	0.7%	5	1.3%	8	1.0%
Mexican/Mexican-American	186	44%	175	44%	361	44%
Puerto Rican	3	0.7%	6	1.5%	9	1.1%
South American	0	0%	2	0.5%	2	0.2%
Other	73	17%	27	7%	100	12%
Non-Hispanic as follows:						
African	69	16%	66	17%	135	16%
Asian Indian/South Asian	5	1.2%	2	0.5%	7	0.9%
Cambodian	4	1.0%	2	0.5%	6	0.7%
Chinese	1	0.2%	0	0%	1	0.1%
Eastern European	1	0.2%	3	0.8%	4	0.5%
European	9	2.1%	7	1.8%	16	2.0%
Filipino	14	3%	5	1.3%	19	2.3%
Japanese	0	0%	0	0%	0	0%
Korean	1	0.2%	0	0%	1	0.1%
Middle Eastern	0	0%	2	0.5%	2	0.2%
Vietnamese	1	0.2%	2	0.5%	3	0.4%
Other	32	8%	28	7%	60	7%
More than one ethnicity	41	10%	38	10%	79	10%
Decline to answer	65	16%	30	8%	95	12%
Primary Language						
English	380	91%	353	88%	733	89%
Spanish	34	8%	45	11%	79	10%
Other	4	1.0%	2	0.0%	6	0.7%
Decline to answer	1	0.2%	0	0%	1	0.1%

Sexual Orientation						
Gay or Lesbian	14	3%	16	4%	30	4%
Heterosexual or Straight	356	85%	312	78%	668	82%
Bisexual	19	5%	31	8%	50	6%
Questioning or unsure	3	0.7%	2	0.5%	5	0.6%
Queer	0	0%	2	0.5%	2	0.2%
Another sexual orientation	7	1.7%	3	0.8%	10	1.2%
Decline to answer	20	5%	34	9%	54	7%
Disability						
Communication - difficulty seeing	16	4%	21	5%	37	5%
Communication - difficulty hearing & speech	5	1.2%	5	1.3%	10	1.2%
Communication - other	0	0%	0	0%	0	0%
Mental disability	44	11%	40	10%	84	10%
Physical/mobility disability	13	3%	3	0.8%	16	2.0%
Chronic health	7	1.7%	4	1.0%	11	1.3%
Other	8	1.9%	13	3%	21	3%
Decline to answer	19	5%	9	2.3%	28	3%
Veteran status						
Yes	1	0.2%	1	0.3%	2	0.2%
No	416	99%	397	99%	813	99%
Decline to answer	2	0.5%	2	0.5%	4	0.5%
Sex assigned at birth						
Male	183	44%	184	46%	367	45%
Female	235	56%	214	54%	449	55%
Decline to answer	1	0.2%	2	0.5%	3	0.4%
Current Gender identity						
Male	180	43%	181	45%	361	44%
Female	232	55%	210	53%	442	54%
Transgender	5	1.2%	3	0.8%	8	1.0%
Genderqueer	1	0.2%	1	0.3%	2	0.2%
Questioning or unsure of gender identity	1	0.2%	1	0.3%	2	0.2%
Another gender identity	0	0%	2	0.5%	2	0.2%
Decline to answer	0	0%	2	0.5%	2	0.2%
Residence						
Stockton	385	92%	338	85%	723	88%
Lodi	8	1.9%	12	3%	20	2.4%
Manteca	9	2.1%	19	5%	28	3%
Tracy	13	3%	14	4%	27	3%
Other	3	0.7%	11	3%	14	1.7%
Decline to answer	0	0%	6	1.5%	6	0.7%

Participant Outcomes

Graduation from this program was defined as participants having completed at least one of their program goals at discharge. According to staff, 67% of youth graduated from CAPC's program and 83% graduated from Women's Center.

TAY Mentoring Outcomes: FY 2016/17 and FY 2017/18						
Instruments: TIP tracker; BHS Outcome Measures Freq. of admin: Baseline and discharge Graduation expectation: 60% participants exit having completed goals	Child Abuse Prevention Council- Total		Women's Center- Total		Total	
Unduplicated individuals served	471		343		814	
Number of graduates (individuals who completed goals)	256	67%	250	83%	506	74%
Number of individuals who exited program	380		303		683	
Number if individuals assessed at discharge	380	100%	303	100%	683	100%

The TIP Tracker rated each participant at discharge on progress towards or the completion of their *self-identified* goals 8 domains. The following table shows 2-year TIP-Tracker outcomes for each program and for the TAY Project as a whole. On average, Women's Center demonstrated better outcomes (75% of youth showed improvement in self-identified goals). For CAPC, 68% of youth showed improvement. Within both programs, improvements were most likely to be made in the domains of social supports (77%), emotional wellbeing (75%), and education (75%). Improvements were least likely to be made in parenting domains (46%) and physical health (59%).

TAY Participant-identified goals	Child Abuse Prevention Council FY 2016/17 and FY 2017/18			Women's Center FY 2016/17 and FY 2017/18			Combined TAY Program Total		
	# with goals in this category	# who showed improve-ment	*% who showed improve-ment*	# with goals in this category	# who showed improve-ment	*% who showed improve-ment*	# with goals in this category	# who showed improve-ment	*% who showed improve-ment*
Education	239	192	*80%*	219	150	*68%*	458	342	*75%*
Employment and career	229	165	*72%*	257	190	*74%*	486	355	*73%*
Living situation	92	57	*62%*	193	141	*73%*	285	198	*69%*
Social support and connections	139	104	*75%*	116	92	*79%*	255	196	*77%*
Emotional and wellbeing	95	64	*67%*	166	132	*80%*	261	196	*75%*
Physical health	56	22	*39%*	50	41	*82%*	106	63	*59%*
Financial	72	33	*46%*	195	163	*84%*	267	196	*73%*
Parenting	40	15	*38%*	71	36	*51%*	111	51	*46%*
Average	120	82	*68%*	158	118	*75%*	279	200	*72%*

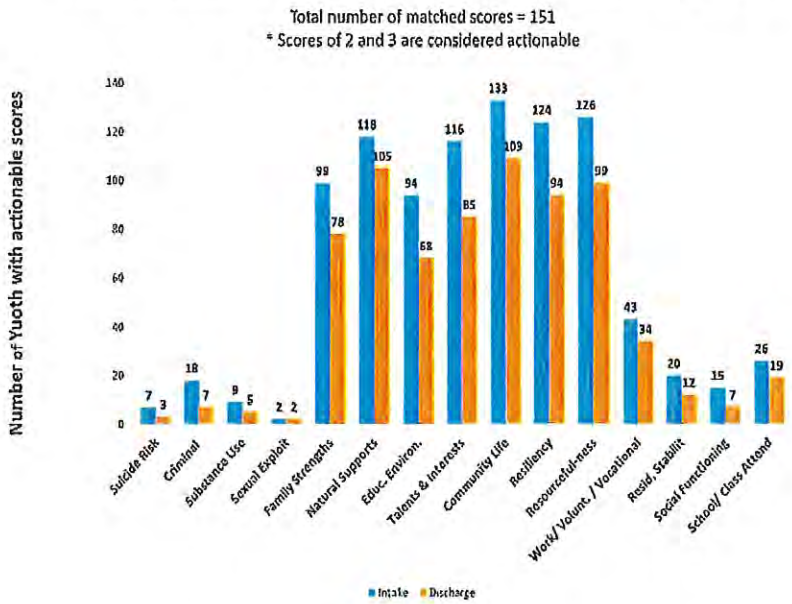
For Fiscal Year 2016-17 another method of measuring outcomes involved a set of 8 objective risk categories selected by SJCBHS. Staff first identified the number of participants who had risks in each category at intake, then determined at discharge if they had demonstrated improvements in those categories.

Findings suggest that overall, Women's Center participants exhibited a greater number of risk factors at intake and demonstrated greater reduction in risk factors at discharge—62% showed reductions in overall risks versus 36% for CAPC. For both programs, some of the greatest improvements were in relation to trauma. The Women's Center was successful in reducing risk of arrests, incarceration and mental health symptoms. CAPC showed the greatest promise in reducing suicide risk, but the number who demonstrated risk in the domain at intake was very small compared to other risk areas.

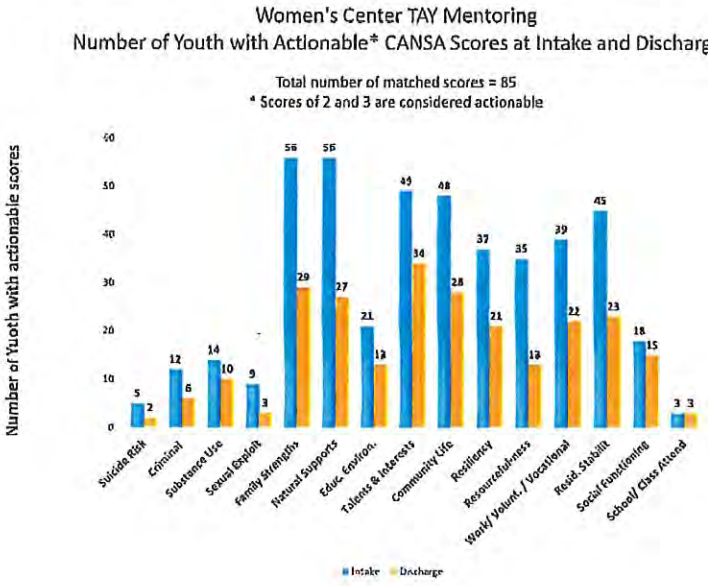
TAY Mentoring Outcomes: FY 2016/17	Child Abuse Prevention Council			Women's Center		
2016/17 BHS-Measures (those with no concerns at intake and who were unknown at discharge removed from denominator)	# at risk at intake	# who showed improve-ment	*% who showed improve-ment*	# at risk at intake	# who showed improve-ment	*% who showed improve-ment*
Employment, volunteering, education	*110*	69	*63%*	69	23	*33%*
Arrests	*13*	10	*77%*	15	7	*47%*
Incarceration	*12*	9	*75%*	10	3	*30%*
Homelessness	*22*	13	*59%*	38	18	*47%*
Alcohol, drug use	*41*	10	*24%*	40	9	*23%*
Suicide	*6*	5	*12%*	5	3	*60%*
Trauma exposure	*32*	26	*81%*	19	10	*53%*
Mental health symptoms	*54*	37	*69%*	26	6	*23%*
Average	*36*	*22*	62%	28	10	36%

In Fiscal Year 2017/18 both CAPC and Women's Center administered CANSAs at intake and discharge for all participants. For CAPC, we found that upon intake, youth were most likely to need support in the development of community life, resiliency, resourcefulness, natural supports and talents and interests. These remained a concern at discharge, but for fewer youth. It is important to note that few CAPC participants showed a need for support around risk factors; mostly they demonstrated a need for support in building their protective factors, suggesting that this program was not targeting youth with the highest risk concerns.

CAPC-TIP
Number of Youth with Actionable* CANSA Scores at Intake and Discharge



For Women's Center, we found that upon intake, youth were most likely to need support to develop family strengths, natural supports, talents and interests, and community life. A significant number and needed support in housing and work/volunteering as well. Overall, youth showed greater improvement in these areas than CAPC youth. Additionally, proportionately, Women's Center youth showed a greater degree of risk at intake, suggesting that the program was targeting youth at higher risk.



Cost/Benefit Analysis

The following table shows several key indicators of performance over a two-year period for each CBO provider and for the TAY Mentoring Project as a whole, including: costs of the Project (represented by amount invoiced), cost per participant and cost per graduate (individual who met at least one of his/her goals). Over the two year period, the cost per individual served was $1,881. Women's Center costs were higher; however, the cost per individual exiting the program having graduated (completed their goals) was higher for CAPC ($3,045) and by this measure, Women's Center was more cost effective.

TAY Mentoring Cost/Benefit: FY 2016/17 and FY 2017/18	CAPC	Women's	Total
Program Costs	$803,549	$737,333	$1,540,883
Unduplicated individuals served	471	348	819
Cost per individual served	*$1,706*	*$2,119*	*$1,881*
Number of participants exiting program	365	303	668
Number who graduated (exited having completed goals)	256	250	506
Cost per graduate	*$3,139*	*$2,949*	*$3,045*

Access and Linkage to Treatment Strategy[7]

In Fiscal Year 2016/17, PEI programs began tracking referrals to treatment. In the 4th quarter of Fiscal Year 2016/17, PEI programs developed more comprehensive referral and linkage tracking policies, procedures, and data systems. Detailed data with demographic information are provided to MHSOAC in a confidential Excel file. The following is a summary of data on referrals from the TAY Mentoring Project.

- In the 4th quarter of Fiscal Year 2016/17, a total of 21 individuals identified by the TAY Mentoring Project were referred to SJCBHS Access for screening and assessment, and to determine eligibility for treatment.

- Three of these individuals engaged in treatment, as defined by participating at least once in treatment. The average duration from referral to treatment was 23.7 days (s= 32.4).

- Sixteen (16) of the 21 individuals provided information on the duration of untreated mental illness. On average, they were experiencing symptoms for 12.1 months (s = 8.2).

- During Fiscal Year 2017/18, the TAY Mentoring Project made 85 referrals to mental health treatment.

[7] All PEI programs involve an Access and Linkage to Treatment Strategy, defined as a set of related activities to connect children, youth, adults, and older adults with severe mental illnesses to medically necessary care and treatment, as early in the onset of these conditions as practical. Examples of Access and Linkage to Treatment Programs, include programs with a primary focus on screening, assessment, referral, telephone help lines, and mobile response. (California Code of Regulations §3726)

- Nineteen (19) of these individuals engaged in treatment, as defined by participating at least once in treatment. The average duration from referral to treatment was 58.8.days (s= 18.9).

- The average duration of untreated mental illness was 10.6 months (s = 18.9).

- Due to the small sample, demographic information on referrals is included in the confidential supplemental file.

Timely Access to Services for Underserved Populations Strategy[8]
San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- In 4th quarter of Fiscal Year 2016/17, all 21 treatment referrals were made for members of underserved populations (many met the criteria for underserved population in two or more demographic categories)

- Three of the individuals participated in the program to which they were referred. The average duration from referral to treatment was 23.7 days (s= 32.4). (A more detailed breakdown of each underserved demographic group is included in the supplemental file.)

[8] "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services. (*CCR, Title 9, 3735)*

- All referred individuals in 2017/18 met the criteria for underserved population as Transitional Age Youth. Seventeen (17) individuals who participated in treatment qualified for two or more categories of underserved population. (A more detailed breakdown of each underserved demographic group is included in the supplemental file.)

Encouraging Access to Services and Follow Through

Per PEI regulations, all programs must describe ways that they encourage access to services and follow through. The following are ways that SJCBHS and the TAY programs encourage access and follow through:

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- CAPC's TAY Mentoring program provides community resources to and informs youth of their options. Staff offers the option of a warm handoff and offers ongoing support to ease the transition to new service providers. Practices from the TIP Model are used to encourage youth to seek services and help maintain treatment if it is needed.

- The Women's Center TAY Mentoring program encourages access to mental health services by offering in-house therapy and referrals to external services when appropriate. The Women's Center helps participants identify what insurance they have, and refers to both private insurance and County Behavioral Health Services. The Women's Center also offers free and confidential peer counseling for victims and their family's dealing with domestic violence and sexual assault.

Coping and Resilience Education Services (CARES)

Project Description

CARES was launched in Fiscal Year 2017/18 as part of the Trauma Services Collaborative with Child Welfare. The program serves children and youth (ages 6-17) who are CPS-involved, exposed to trauma, or referred by Child Welfare, but who do not meet medical necessity for specialty mental health services, and their caregivers. Children and youth, ages 5 - 18, are screened for trauma-related symptoms, and children receive short-term problem solving, safety planning, coping and resiliency skill-building services using an individualized *Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Disorders* (MATCH-ADTC). Resource families receive trauma-informed training using the *Parents Reach Achieve and eXcel through Empowerment Strategies* (PRAXES) curriculum. Staff provide one-on-one and group support.

In addition, in coordination with the County's Human Services Agency, project staff attended Child Family Team (CFT) meetings with children and family members who are not already to be connected to behavioral health services. The project also facilitated *Caring for Children who have Experienced Trauma* trainings in the causes and effects of childhood trauma to resource families, teachers, and group home providers.

Project Outputs

In Fiscal Year 2017/18, 92 of the 102 (90%) of the children screened into CARES participated in the MATCH-ADTC program. Fifty-four (54) parents/caregivers participated in PRAXES. Each parent/child received, on average, 9 sessions. In addition, staff attended 93 CFT meetings and facilitated 10 Trauma trainings with resource families

CARES Output: FY 2017/18	
Number of Children Screened into Program	102
Number of Parents Who Participated in PRAXES	54
Number of Children Participated in MATCH-ADTC	92
Number of Sessions Delivered	1375
Number of Sessions per Individual	9
Number of CFT meetings attended	93
Number of Trauma Trainings for resource families	10
Number of individuals trained	127

Participant Demographics

Demographic forms were collected for caregivers and children. Sixty-three percent of CARES participants were children; 47% identified as Mexican/Mexican American; 18% as White and 16% as Black or African American. Eighteen percent of the participants spoke Spanish as their primary language. More participants (53%) identified as male than female (37%), and the remainder declined to answer or identified with another gender identity.

CAREs Demographics	FY 2017/18	
Unduplicated individuals served	146	
Number of demographic forms collected	146	100%
Ages*		
Children	92	63%
Adults	54	37%
Race		
American Indian or Alaskan Native	0	0%
Asian	1	0.7%
Black or African American	23	16%
Native Hawaiian or other Pacific Islander	1	0.7%
White	26	18%
Other	55	38%
More than one race	31	21%
Decline to answer	9	6%
Ethnicity		
Hispanic or Latino as follows:		
Caribbean	0	0%
Central America	0	0%
Mexican/Mexican-American	68	47%
Puerto Rican	2	1.4%
South American	0	0%
Other	4	2.7%
Non-Hispanic as follows:		
African	2	1.4%
Asian Indian/South Asian	0	0%
Cambodian	1	0.7%
Chinese	0	0%
Eastern European	2	1.4%
European	4	3%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	1	0.7%
Other	21	14%
More than one ethnicity	28	19%
Decline to answer	12	8%
Primary Language		
English	115	79%
Spanish	27	18%
Cambodian	0	0%
Other	0	0%
Decline to answer	4	3%

Sexual Orientation		
Gay or Lesbian	0	0%
Heterosexual or Straight	91	62%
Bisexual	2	1.4%
Questioning or unsure	1	0.7%
Queer	0	0%
Another sexual orientation	1	0.7%
Decline to answer	51	35%
Disability		
Communication - difficulty seeing	3	2.1%
Communication - difficulty hearing & speech	2	1.4%
Communication - other	0	0%
Mental disability	4	3%
Physical/mobility disability	2	1.4%
Chronic health	1	0.7%
Other	5	3%
Decline to answer	8	5%
Veteran status		
Yes	0	0%
No	141	97%
Decline to answer	5	3%
Sex assigned at birth		
Male	82	56%
Female	60	41%
Decline to answer	4	3%
Current Gender Identity		
Male	77	53%
Female	54	37%
Transgender	0	0%
Genderqueer	0	0%
Questioning or unsure of gender identity	1	0.7%
Another gender identity	0	0%
Decline to answer	13	9%
Residence		
Stockton	104	71%
Lodi	12	8%
Manteca	11	8%
Tracy	8	5%
Other	8	5%
Decline to answer	3	2.1%

**Ages Not Collected Correctly*

Participant Outcomes-Parental Stress Index

There were 54 parents who participated in PRAXES, of whom 38 were assessed at intake. Fifteen parents (39% of those assessed at intake) graduated from the program (i.e., were assessed at discharge) during the fiscal year; the remainder continued with services in the subsequent fiscal year. The Parental Stress Index includes 4 domains and a total stress score. Fewer than half showed improvements in Parental Distress (33%); Parent Child Difficult Interactions (47%) and DR (47%). Two-thirds showed improvement in Difficult Child domain (67%) and slightly more than half showed improvement in total stress scores (53%). The mean scores declined (improved) in all domains, demonstrating the strength of improvement.

CARES Outcomes FY 2017/18	Parental Stress Index				
Number of PRAXES participants (parents) assessed at intake	38				
Number of parents assessed at discharge (i.e., graduates)	15			39%	
Parental Stress Index	DR	PD	P-CDI	DC	Total
Number of individuals showing improvement (lower score post test)	7 (47%)	5 (33%)	7 (47%)	10 (67%)	8 (53%)
Mean Pre Score	15.1	24.7	25.4	28.5	78.7
Mean Post Score	14.1	23.3	24.5	25.8	72.1
Mean difference	-1.0	-1.4	-0.9	-2.7	-6.5
Standard Deviation of Difference	4.0	6.9	6.3	7.6	15.6

Participant Outcomes-Eyberg Child Behavior Inventory (ECBI)

The ECBI is administered to parents/guardians and provides information about the frequency and severity of their child's behavior problems, as well as the extent to which parents find the behavior troublesome. More than two-thirds (69%) of participants demonstrated improvements in both domains.

CARES Outcomes FY 2017/18	Eyberg Child	
Number of PRAXES participants (parents) assessed at intake	38	
Number of parents assessed at discharge (i.e., graduates)	15	39%
Eyberg Child Behavior Inventory	Intensity Score	Problem Score
Number of individuals showing improvement (lower score post test)	9	9
Mean Pre Score	49.2	49.9
Mean Post Score	44.9	46
Mean Difference	-4.3	-3.9
Standard Deviation of Difference	6.2	10.2

Cost/Benefit Analysis

The following table shows the cost per individual served with either PRAXES, MATCH-ADTC, CFT meetings[9], or trauma trainings. PRAXES and MATCH-ADTC clients received ongoing services, while CFT meetings and trauma trainings were one-time activities. Thus, costs for individuals served by PRAXES and MATCH-ADTC were in actuality significantly higher than for those receiving CFT meetings and trauma trainings.

CAREs Cost/Benefit	2017/18
Program Costs	$829,211
Individuals served (PRAXES, MATCH-ADTC, CFT mtgs, trauma trainings)	366
Cost per individual served	*$2,266*

Access and Linkage to Treatment Strategy

Detailed referral and linkage data with demographic information are provided in a secure confidential Excel file. The following is a summary of data on referrals from CARES for Fiscal Year 2017/18.

- CARES reported making 30 referrals to treatment in Fiscal Year 2017/18.
- Nine (9) of these individuals (30%) engaged in treatment, as defined by participating at least once in treatment. The average duration from referral to treatment was 21.8 days (s = 16.5).
- For these 9 individuals, the average duration of untreated mental illness was 13.3 months (s= 12.1)

Timely Access to Services for Underserved Populations Strategy[10]

Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

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[9] While CFT meetings involve more than one individual, only one individual was counted per meeting.

[10] San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention: A)

- Twenty (20) individuals referred to treatment by CAREs were members of underserved populations (several individuals referred met the criteria for underserved population in two demographic categories)

- Four (4) individuals (20%) who received treatment were members of underserved populations.

Encouraging Access to Services and Follow Through

Per PEI regulations, all programs must describe ways that they encourage access to services and follow through. The following are ways that CARES encourages access and follow through:

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- CARES referrals are processed and assigned quickly. The referral process includes three phone contact attempts. If staff are unsuccessful in these attempts, a visit to the home is made, if appropriate. If all contact attempts are unsuccessful, a letter is sent to the home that includes contact information for the program. Collaboration with referral sources is ongoing.

- Program hired more Spanish-speaking Mental Health Outreach workers in order to provide linguistic and culturally relevant interventions for Spanish-speaking families who have been referred.

- Staff attend CFT meetings and maintain communication with referral sources, teachers, and other relevant individuals to ensure a continuum of care.

Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations.

Early Intervention Programs[11]

Trauma Services for Children Program

Project Description

The Trauma Services for Children Program was delivered by Valley Community Counseling Services (VCCS). VCCS provided Child Welfare Trauma Training Toolkit's evidence-based trauma training to educators in San Joaquin County elementary schools; screened students exposed to traumatic events using Trauma Symptom Checklist (TSCL); and provided Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to those experiencing symptoms of traumatic exposure.

Project Outputs

By Fiscal Year 2017/18, Trauma Services were provided in 74 schools. In the first year, 1714 educators were trained and in the subsequent year 1568 educators were trained in trauma-informed care. A total of 1171 trauma screenings were provided over the course of two years, with 471 receiving TF-CBT. On average, children received slightly more than 9 sessions of TF-CBT.

Valley Trauma Services Output FY 2016/17 and FY 2017/18	2016/17	2017/18	Total
Number of elementary schools served	66	74	140
Number of educators trained	1714	1568	3282
Number of trauma screenings	641	530	1171
Number of students receiving TF-CBT	300	171	471
Average number of TF-CBT sessions provided per child	7.8	10.7	9.3

Participant Demographics

Demographics were reported for children who were opened to the Trauma Services Reporting Unit (n= 523). Ninety (90%) percent of these children received at least one session of TF-CBT. All participants were under the age of 15. The majority (56%) identified as White; 31% identified as Latino/Hispanic (Mexican/Mexican American). Spanish was the primary language for 15%. More than half (55%) of participants were

[11] Early Intervention programs provide treatment and other services or interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including addressing the applicable negative consequences that may result from an untreated mental illness.

male at birth. The program did not collect sexual orientation or current gender identity data. Slightly more than half (52%) lived in Stockton, and nearly a quarter (23%) were from Tracy.

Valley Trauma Services Demographics	Valley Trauma Service 2016/17		Valley Trauma Services 2017/18		Total	
Unduplicated individuals served	312		211		523	
Number of demographic forms collected	312		211		523	
Ages						
0-15	312	100%	211	100%	523	100%
16-25	0	0%	0	0%	0	0%
26-59	0	0%	0	0%	0	0%
60+	0	0%	0	0%	0	0%
Decline to answer	0	0%	0	0%	0	0%
Number of children <26 of participants	0	n/a	0	0%	0	0%
Race						
American Indian or Alaskan Native	3	1.0%	4	1.9%	7	1.3%
Asian	4	1.3%	6	3%	10	1.9%
Black or African American	30	10%	18	9%	48	9%
Native Hawaiian or other Pacific Islander	0	0%	2	0.9%	2	0.4%
White	180	58%	111	53%	291	56%
Other	0	0%	0	0%	0	0%
More than one race	49	16%	32	15%	81	15%
Decline to answer	46	15%	38	18%	84	16%
Ethnicity						
Hispanic or Latino as follows:						
Caribbean	0	0%	0	0%	0	0%
Central America	0	0%	0	0%	0	0%
Mexican/Mexican-American	102	33%	60	28%	162	31%
Puerto Rican	0	0%	0	0%	0	0%
South American	0	0%	0	0%	0	0%
Other	0	0%	3	1.4%	3	0.6%
Non-Hispanic as follows:						
African	30	10%	14	7%	44	8%
Asian Indian/South Asian	2	0.6%	2	0.9%	4	0.8%
Cambodian	1	0%	2	0.9%	3	0.6%
Chinese	0	0%	0	0%	0	0%
Eastern European	0	0%	0	0%	0	0%
European	64	21%	0	0%	64	12%
Filipino	1	0.3%	0	0%	1	0.2%
Japanese	0	0%	1	0.5%	1	0.2%
Korean	0	0%	0	0%	0	0%
Middle Eastern	0	0%	0	0%	0	0%
Vietnamese	0	0%	1	0.5%	1	0.2%
Other	3	1.0%	2	0.9%	5	1.0%
More than one ethnicity	49	16%	21	10%	70	13%
Decline to answer	46	15%	53	25%	99	19%
Primary Language						
English	225	72%	178	84%	403	77%
Spanish	49	16%	27	13%	76	15%
Other	3	1.0%	2	0.9%	5	1.0%
Decline to answer	4	1.3%	4	1.9%	8	1.5%

Sexual Orientation						
did not collect	312	*100%*	211	*100%*	523	*100%*
Disability						
Communication - difficulty seeing	3	*1.0%*	2	*0.9%*	5	*1.0%*
Communication - difficulty hearing & speech	0	*0%*	1	*0%*	1	*0.2%*
Communication - other	0	*0%*	0	*0%*	0	*0%*
Mental disability	0	*0%*	0	*0%*	0	*0%*
Physical/mobility disability	3	*1.0%*	0	*0%*	3	*0.6%*
Chronic health	0	*0%*	0	*0%*	0	*0%*
Other	5	*1.6%*	0	*0%*	5	*1.0%*
Decline to answer	22	*7%*	16	*8%*	38	*7%*
Veteran status						
Did not collect	312	*100%*	211	*100%*	523	*100%*
Sex assigned at birth						
Male	170	*54%*	116	*55%*	286	*55%*
Female	141	*45%*	95	*45%*	236	*45%*
Decline to answer	0	*0%*	0	*0%*	0	*0%*
Current Gender Identity						
Did not collect	312	*100%*	211	*100%*	523	*100%*
Residence						
Stockton	147	*47%*	125	*59%*	272	*52%*
Lodi	36	*12%*	13	*6%*	49	*9%*
Manteca	38	*12%*	18	*9%*	56	*11%*
Tracy	69	*22%*	51	*24%*	120	*23%*
Other	22	*7%*	4	*1.9%*	26	*5%*
Decline to answer	0	*0%*	0	*0%*	0	*0%*

Participant Outcomes

During the reporting period, 310 children completed TF-CBT. This represents a completion rate of 66%. Of those who completed TF-CBT, 307 (99%) had matched pre and post TSCL scores. A total of 209 children (68% of matched pre post surveys) demonstrated a reduction in trauma symptoms.

Valley Trauma Program						
Instrument: Trauma Symptom Checklist **Freq. of admin:** First and last session	2016/17		2017/18		Total	
Unduplicated individuals served	300		171		471	
Average number of sessions per participant	7.8		10.7		9.3	
Number of program completions	151	*50%*	159	*93%*	310	*66%*
Number of graduates w/ matched pre/post	148	*98%*	159	*100%*	307	*99%*
Number showing improvement in Trauma Symptoms	103	*70%*	106	*67%*	209	*68%*

In fiscal year 2017/18, 159 matched CANSA scores were recorded and 140 individuals (88%) showed improved CANSA scores at completion of the therapy.

CANSA Assessment 2017/18		
Number of Graduates w matched pre/post CANSA scores	159	
Number of Graduates with Improved CANSA scores	140	*88%*

Cost/Benefit Analysis

Over the two year period, Valley Trauma Services invoiced $1,337,211 for direct services, which calculated to $2,839 per child receiving TF-CBT. A total of $4,314 was spent per child completing TF-CBT and $6,398 per child demonstrating improvement. The cost per educator for trauma training was $16.99.

Valley Trauma Services FY 2016/17 and FY 2017/18	2016/17	2017/18	Total
Direct service costs	$715,950	$621,261	$1,337,211
Unduplicated individuals receiving TF-CBT	300	171	471
Cost per individual receiving early intervention	*$2,387*	*$3,633*	*$2,839*
Number of individuals completing TF-CBT	151	159	310
Cost per individual completing program	*$4,741*	*$3,907*	*$4,314*
Number who showed improvement	103	106	209
Cost per individual who showed improvement	*$6,951*	*$5,861*	*$6,398*
Number of Educators trained	1714	1568	3282
Cost of Educator Training	$28,125	$27,623	$55,748
Cost Per Educator Trained	*$16.41*	*$17.62*	*$16.99*

* In 2016/17 program invoiced a total of $744,075 of which $28,125 was used for Trauma Training. The $715,950 represents costs associated with screening and providing TF-CBT. In 2017/18, a total of $621,261 was spent on direct services and $27,623 on educator trainings.

Access and Linkage to Treatment Strategy

In Fiscal Year 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early Fiscal Year 2016/17, SJCBHS and PEI contractors developed more comprehensive referral tracking policies, procedures, and data systems, and began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs in 4th quarter. Detailed data with demographic information are provided to MHSOAC in a secure confidential Excel file. The following is a summary of data on referrals from the Trauma Services for Children Project.

- In fiscal year 2016/17, the Trauma Services Project reported making 73 referrals to treatment.

- In the 4th quarter of fiscal year 2016/17, during the period when referrals were more comprehensively tracked, a total of 10 individuals identified by the Trauma Services Project were referred to SJCBHS for screening and assessment and to determine eligibility for treatment.

- Nine (9) of these individuals engaged in treatment, as defined by participating at least once in treatment. The average duration from referral to treatment was 8.8 days (s = 11.8).

- The program did not capture data on duration of untreated mental illness during the Fiscal Year, but received additional training to do so in the subsequent reporting period.

- In fiscal year 2017/18 the Trauma Services Project reported making 81 referrals to treatment in Fiscal Year 2017/18.

- Fifty-seven (57) of these individuals engaged in treatment, as defined by participating at least once in treatment. The average duration from referral to treatment was 20.4 days (s = 47.3).

- The program did not capture data on duration of untreated mental illness during the Fiscal Year in spite of additional training.

- Due to the small sample sizes, demographic information on referrals for each fiscal year is included in the confidential supplemental file.

Timely Access to Services for Underserved Populations Strategy[12]
Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

[12] San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations.

- In the final quarter of Fiscal Year 2016/17, Seven (7) treatment referrals were made for members of underserved populations (many met the criteria for underserved population in two or more demographic categories).

- Six (6) of the individuals participated in the program to which they were referred. The average duration from referral to treatment was 3.3 days (s = 5.2). (A more detailed breakdown of each underserved demographic group is included in the supplemental file.)

- In fiscal year 2017/18, 40 treatment referrals were made for members of underserved populations (many met the criteria for underserved population in two or more demographic categories)

- 29 of the individuals participated in the program to which they were referred. Average duration from referral to treatment was 8.4 days (s = 10.1). (A more detailed breakdown of each underserved demographic group is included in the supplemental file.)

- Due to the small sample, demographic information on referrals in included in the confidential supplemental file.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the Trauma Services Project encourage access to services and follow through:

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- VCCS makes direct referrals from its PEI program to its treatment program if an individual is identified as meeting medical necessity. In these circumstances, the individual may in fact experience no service provider transition. All VCCS staff have a directive to keep routine contact with school administrators and teachers regarding referrals and active cases. Staff members make routine calls to parents and solicit assistance from school personnel to schedule intakes for students who are screened and in need of services.

Early Interventions to Treat Psychosis

Project Description

The Early Interventions to Treat Psychosis (EITP)/Telecare Early Intervention and Recovery Services (TEIR) program provides an integrated set of promising practices that research indicates will slow the progression of psychosis early in its onset. The EITP program offers a combination of outreach, engagement, and evidenced-based treatments and supports, delivered to individuals throughout San Joaquin County, age 14-34, who have experienced their first full psychotic episode in the past two years or who are showing prodromal symptoms of psychosis.

The TEIR Project follows the evidence based Portland Identification and Early Referral (PIER) model, and provides an integrated set of promising practices designed to slow the progression of psychosis early in its onset. The project goal is to identify and provide treatment to individuals who have experienced their first full psychotic episode in the past two years or who are showing prodromal symptoms of psychosis in order to prevent disability and the onset of the acute stage of illness.

Project Outputs

A total of 46 individuals were served in Fiscal Years 2016/17 and 2017/18.
The following table shows the number of psychosis screenings completed during the fiscal year, the number of screenings that resulted in program eligibility, and the number of individuals and family members who participated in the program.

Telecare Output	2016/17	2017/18	Total
Number of early psychosis screenings completed	36	25	61
Number of screenings that resulted in program eligibility	23	11	34
Total unduplicated count of individuals receiving early intervention	38*	8†	46
Number of family members who participated in program	13	32	n/a

*Includes individuals rolled over from previous Fiscal Year
† Excludes individuals rolled over from previous Fiscal Year

Participant Demographics

Demographics are reported for TEIR for both fiscal years. We were unable to report for the two year period because most of the participants in Fiscal Year 2017/18 rolled over from the previous year. The demographic reports suggest that nearly all of the

participants were transitional age youth (one individual may have aged out of this category during their tenure in the program). In the second year, 27% identified as Hispanic/Latino, and in the second year, 35% identified as Black/African American. English was the primary language for all Participants. In the second year, 65% reported that their current gender identity was male, 32% female and 3% transgender. Ninety-two percent each year identified as heterosexual, none were veterans and 84% lived in Stockton.

Telecare Demographics	2016/17		2017/18	
Individuals served	38		37	
Number of demographic forms collected	38		37	100%
Ages				
0-15	0	0%	0	0%
16-25	38	100%	36	97%
26-59	0	0%	1	3%
60+	0	0%	0	0%
Decline to answer	0	0%	0	0%
Number of children <26 of participants	0	n/a	0	0%
Race				
American Indian or Alaskan Native	1	3%	0	0%
Asian	2	5%	3	8%
Black or African American	8	21%	13	35%
Native Hawaiian or other Pacific Islander	0	0%	0	0%
White	9	24%	4	11%
Other	13	34%	15	41%
More than one race	5	13%	2	5%
Decline to answer	0	0%	0	0%
Ethnicity				
Hispanic or Latino as follows:				
Caribbean	0	0%	0	0%
Central America	0	0%	0	0%
Mexican/Mexican-American	13	34%	10	27%
Puerto Rican	0	0%	0	0%
South American	0	0%	0	0%
Other	9	24%	0	0%
Non-Hispanic as follows:				
African	1	3%	10	27%
Asian Indian/South Asian	0	0%	0	0%
Cambodian	0	0%	0	0%
Chinese	1	3%	1	3%
Eastern European	0	0%	0	0%
European	0	0%	3	8%
Filipino	1	3%	1	3%
Japanese	0	0%	0	0%
Korean	1	3%	1	3%
Middle Eastern	0	0%	0	0%
Vietnamese	0	0%	0	0%
Other	9	24%	0	0%
More than one ethnicity	3	8%	10	27%
Decline to answer	0	0%	1	3%
Primary Language				
English	38	100%	37	100%
Spanish	0	0%	0	0%
Other	0	0%	0	0%
Decline to answer	0	0%	0	0%

	2016/17		2017/18	
Sexual Orientation				
Gay or Lesbian	1	3%	1	3%
Heterosexual or Straight	35	92%	34	92%
Bisexual	0	0%	0	0%
Questioning or unsure	0	0%	0	0%
Queer	1	3%	1	3%
Another sexual orientation	1	3%	0	0%
Decline to answer	0	0%	1	3%
Disability				
Communication - difficulty seeing	1	3%	2	5%
Communication - difficulty hearing & speech	0	0%	0	0%
Communication - other	0	0%	0	0%
Mental disability	1	3%	2	5%
Physical/mobility disability	0	0%	0	0%
Chronic health	0	0%	0	0%
Other	1	3%	1	3%
Decline to answer	0	0%	2	5%
Veteran status				
Yes	0	0%	0	0%
No	38	100%	37	100%
Decline to answer	0	0%	0	0%
Sex assigned at birth				
Male	26	68%	24	65%
Female	12	32%	13	35%
Decline to answer	0	0%	0	0%
Current Gender Identity				
Male	23	61%	24	65%
Female	14	37%	12	32%
Transgender	0	0%	1	3%
Genderqueer	0	0%	0	0%
Questioning or unsure of gender identity	0	0%	0	0%
Another gender identity	0	0%	0	0%
Decline to answer	1	3%	0	0%
Residence				
Stockton	33	87%	31	84%
Lodi	1	3%	1	3%
Manteca	2	5%	2	5%
Tracy	2	5%	3	8%
Other	0	0%	0	0%
Decline to answer	0	0%	0	0%

Participant Outcomes

During the two-year reporting period, 16 participants discharged from services, of those, six (38%) completed program objectives. Participants were assessed at intake and again at 12 months and at discharge. If a client had discharged, we measured outcomes from discharge date. If they were still in the program and had completed 12 months, we measured their outcomes at 12 months.

No participants graduated from high school between intake and discharge. Over half (54%) showed improvements in employment and/or educational goals. While only a small proportion were homeless at intake (5%) even fewer were homeless at discharge or 12 months (3%). Nineteen percent (19%) had been hospitalized and 8% had been arrested or incarcerated between intake and 12 months or discharge.

Telecare TEIR Outcomes FY 2016/17 and FY 2017/18: Milestones	Total	%
Number of participants w/ matched 12-month assessments and/or discharge assessment	37	
Number who Graduated from Highschool or obtained GED between intake and discharge	0	*0%*
Number who showed improvement in employment and education	20	*54%*
Number who showed decline in employment and education	5	*14%*
Number who were homeless at intake	2	*5%*
Number who were homeless or unknown housing status at discharge	1	*3%*
Arrests/incarcerations between intake and discharge or 12 months	3	*8%*
Psychiatric hospitalizations between intake and discharge or 12 months	7	*19%*

In the reporting period 27 matched CANSA/ANSA scores were recorded at intake and 12 months, and 15 (55%) of these showed overall improvement and 11 (41%) showed decline at 12 months. Fifteen (15) clients had CANSA/ANSA scores at 24 months. Of those (66%) showed improvement, suggesting that the longer the participant is in the program the greater the improvement.

TEIR Outcomes FY 2017/18								
TEIR C/ANSA	Number of matched assessments	Risk Factors				Life Domains			
		Improved		Declined		Improved		Declined	
Intake–12 months	27	15	55.6%	4	14.8%	8	29.6%	13	48.1%
Intake–24 Months	15	9	60.0%	3	20.0%	3	20.0%	10	66.7%
Intake–Discharge	5	1	20.0%	0	0.0%	5	100.0%	0	0.0%
12 month– Discharge or most recent	16	8	50.0%	0	0.0%	9	56.3%	4	25.0%
TEIR C/ANSA	Number of matched assessments	Strength				Combined Total			
		Improved		Declined		Improved		Declined	
Intake–12 months	27	14	51.9%	9	33.3%	15	55.6%	11	40.7%
Intake–24 Months	15	10	66.7%	4	26.7%	10	66.7%	5	33.3%
Intake–Discharge	5	4	80.0%	1	20.0%	5	100.0%	0	0.0%
12 month– Discharge or most recent	16	11	68.8%	4	25.0%	14	87.5%	2	12.5%

Eleven (11) matched SIPS/SOPS scores were recorded at intake and 6 months, and 13

matched SIPS/SOPS scored were recorded at 12 months. Nearly all (93%) showed improvement after 6 months, and this improvement was sustained at one year.

SIPS/SOPS FY 2016/17 and FY 2017/18		
Number of matched baseline/6-month SIPS/SOPS assessments completed during reporting period	15	
Number that demonstrate improvement through a decrease in score	14	*93%*
Number of matched baseline/12-month SIPS/SOPS assessments completed during reporting period	12	
Number that demonstrate improvement through a decrease in score	12	*100%*
Number of matched baseline/discharge SIPS/SOPS assessments completed during reporting period	2	
Number that demonstrate decrease of one full scale level	2	*100%*

Cost/Benefit Analysis

The following table shows several key indicators of performance for the TEIR Project, including: costs of the project (represented by amount invoiced), cost per participant, and cost per individual having completed program objectives. Again, it is important to note that the program is designed to serve participants for two years. Most of the participants have been in services fewer than two years, thus the costs per individual demonstrating improved outcomes is expected to increase.

Telecare TEIR Cost/Benefit: FY 2016/17 and FY 2017/18	Total
Program Costs (i.e., $ invoiced by contractor)	$1,126,429
Unduplicated individuals receiving early intervention	46
Cost per individual receiving early intervention	*$24,488*
Number of individuals discharging from program	14
Number of individuals discharging having completed their objectives	*6*
Cost per individual demonstrating improved outcomes	*$187,738*

Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy

TEIR conducted 89 outreach presentations and events reaching a total of 1511 potential responders. Outreach occurred primarily in educational settings, behavioral health programs, and other social services. Potential responders included family members, legal support staff and employers, in addition to the general public.

Outreach	2016/17	2017/18	Total
Number of individuals reached via outreach (i.e., potential responders)	822	689	1511
Settings in which potential responders were engaged			
Mental Health/Behavioral Health	4	13	17
Other Social Service	14	9	23
Primary Health Clinics/Hospitals	5	3	8
Educational settings	14	12	26
Faith-based	0	0	0
Other	8	7	15
Total number of outreach presentations/events	45	44	89
Types of potential responders: general public; family members; legal support staff; employers			

Access and Linkage to Treatment Strategy

In Fiscal Year 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early Fiscal Year 2016/17, SJCBHS and PEI contractors developed more comprehensive referral tracking policies, procedures, and data systems, and began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs in 4th quarter. Detailed data with demographic information are provided to MHSOAC in a secure confidential Excel file. The following is a summary of data on referrals from the EITP Project.

- The TEIR Project reported making 8 referrals to treatment in the 4th quarter of 2016/17. Two of the eight (2) referred individuals engaged in treatment in 2016/17. Average duration from referral to treatment was 171 days (s = 29.7).

- Four individuals were referrals to treatment in Fiscal Year 2017/18. One (1) of these individuals received treatment within 17 days of referral.

- The average duration of untreated mental illness for those referred in 2016/17 was 5.5 months (s = 3.5) and in 2017/18 was 8.5 months (s=10.6)

- Due to the small samples, demographic information on referrals in included in the confidential supplemental file.

Timely Access to Services for Underserved Populations Strategy[13]
Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- Four (4) treatment referrals were made for members of underserved populations in 2016/17. All treatment referrals in 2017/18 were made for members of underserved populations (several met the criteria for underserved population in two or more demographic categories).

- Two (2) of the individuals from underserved populations participated in the program to which they were referred in 2016/17. The average duration from referral to treatment was 171 days (s = 29.7). One (1) of the individuals from underserved populations participated in the program to which they were referred in 2017/18.

- Due to the small samples, demographic information on referrals in included in the confidential supplemental file.

Encouraging Access to Services and Follow Through
The following are ways in which SJCBHS and the TEIR project encourage access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- If individuals do not qualify for TEIR but still meets medical necessity, they are referred to treatment. Staff maintain contact until they begin receiving the services to which they were referred. Telecare also offers welcoming environment by having a bilingual (Spanish) receptionist who focuses on

[13] San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations.

hospitality and building rapport at the initial visit. Telecare has a collaborative relationship with its partner organizations. Staff from these organizations who work with the TEIR team to help them identify relevant resources and services.

- During the initial session with a new participant and their family members, TEIR reviews a welcome packet that gives an overview of staff, program, and what the first month of treatment will look like.

Family Therapy for Children and Youth

Project Description

During the final quarter of Fiscal Year 2017/18, SJCBHS's Children and Youth Services (CYS) began providing family therapy and the evidence-based Strengthening Families training program with children with recent diagnoses of SED, their siblings and parents. Therapy is provided at CYS and in the community by a team of clinical staff (for children) and outreach workers (for parent support). In addition to individual support, families participate in 14-session skill-building groups. The intention of this early intervention program is to prevent the need for longer term treatment. These family-oriented intervention services are provided concurrent with child-centered specialty mental health services for children who were recently diagnosed with SED.

Project Outputs

During Fiscal Year 2017/18, CYS offered three Strengthening Families groups, involving 35 primary children and youth, 6 siblings, and 44 parents/guardians. On average, each group served 15 parents and 14 children. On average, children and their parents attended 8 of the 14 sessions. The program delivered a total of 137 individual family sessions resulting in an average of 4 individual services per child.

Strengthening Families Output FY 2017/18		
Total unduplicated count	**95**	
Unduplicated count of youth served	35	*37%*
Number of **parents/guardians** or other adult family members who participated in at least one group or individual session	44	*46%*
Number of **siblings** or other youth family members who participated in at least one group or individual session	6	*6%*
Number of Youth Graduated	10	*29%*
Number of Parents Graduated	11	*25%*
Number of Siblings Graduated	4	*67%*
Number of Sessions Provided	42	
Average Number of Sessions per Youth	8	
Average Number of Sessions per Attendee (Primary Client, Parents, Siblings)	7.7	

Participant Demographics

Demographics were reported for 17 (18%) of the 95 primary participants. Proportionately too few forms were collected to be able to infer the demographic makeup of all program participants.

Strengthening Families Demographics		
Unduplicated individuals served	95	
Number of demographic forms collected	17	18%
Ages		
0-15	11	65%
16-25	4	24%
26-59	2	12%
60+	0	0%
Decline to answer	0	0%
Race		
American Indian or Alaskan Native	1	6%
Asian	0	0%
Black or African American	3	18%
Native Hawaiian or other Pacific Islander	1	6%
White	7	41%
Other	2	12%
More than one race	2	12%
Decline to answer	1	6%
Ethnicity		
Hispanic or Latino as follows:		
Caribbean	0	0%
Central America	0	0%
Mexican/Mexican-American	3	18%
Puerto Rican	0	0%
South American	0	0%
Other	0	0%
Non-Hispanic as follows:		
African	3	18%
Asian Indian/South Asian	1	6%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Other	2	12%
More than one ethnicity	4	24%
Decline to answer	4	24%
Primary Language		
English	17	100%
Spanish	0	0%
Other	0	0%
Decline to answer	0	0%

Sexual Orientation		
Gay or Lesbian	1	6%
Heterosexual or Straight	12	71%
Bisexual	0	0%
Questioning or unsure	0	0%
Queer	0	0%
Another sexual orientation	0	0%
Decline to answer	4	24%
Disability		
Communication - difficulty seeing	1	6%
Communication - difficulty hearing & speech	1	6%
Communication - other	0	0%
Mental disability	4	24%
Physical/mobility disability	1	6%
Chronic health	1	6%
Other	0	0%
Decline to answer	2	12%
Veteran status		
Yes	0	0%
No	15	88%
Decline to answer	2	12%
Sex assigned at birth		
Male	7	41%
Female	9	53%
Decline to answer	1	6%
Current Gender Identity		
Male	6	35%
Female	9	53%
Transgender	0	0%
Genderqueer	0	0%
Questioning or unsure of gender identity	0	0%
Another gender identity	0	0%
Decline to answer	2	12%
Residence		
Stockton	15	88%
Lodi	1	6%
Manteca	0	0%
Tracy	0	0%
Other	0	0%
Decline to answer	1	6%

Participant Outcomes

Strengthening Families used two outcome surveys administered to parents: Parenting Scale; and Youth Outcome Questionnaire (YOQ). The program uses the Youth Outcome Questionnaire Self Report with children/youth, but only three matched surveys were collected, and thus not reported.

Parenting Scale

The program collected 16 matched pre and post Parenting Scale assessments. Thirty-eight (38%) percent showed overall improvement in scores whereas 50% showed a decline. Greatest improvement was shown in laxness domain whereas least improvement was in verbosity.

Youth Outcome Questionnaire

The program collected 18 matched pre and post YOQs to measure parent's perception of youth outcomes. Overall outcomes improved for 94% of youth. The greatest improvements were made in interpersonal distress and the fewest improvements were made in interpersonal relations domain.

Strengthening Families Outcomes: FY 2017/18		
Parent Scale		
Number of Pre Assessments	33	
Number of Post Assessments	16	*48%*
Number who showed improvement in laxness	8	*50%*
Number who showed improvement in Over-reactivity	7	*44%*
Number who showed improvement in verbosity	5	*31%*
Number showing improvement in at least two areas	7	*44%*
Number showing overall improvement	6	*38%*
Number showing overall decline	8	*50%*
YOQ		
Number of pre assessments	31	
Number of Post Assessments	18	*58%*
Number Who Showed Improvement in Intrapersonal Distress Score	15	*83%*
Number Who Showed Improvement in Somatic Score	11	*61%*
Number Who Showed Improvement in Interpersonal Relations Score	9	*50%*
Number Who Showed Improvement in Social Problems Score	13	*72%*
Number Who Showed Improvement in Behavioral Dysfunction Score	11	*61%*
Number Who Showed Improvement in Critical Items Score	14	*78%*
Number Who Showed Improvement in Total Score	17	*94%*

Cost/Benefit Analysis

According to the MHSA Spending and Expenditure Report, the cost of this program was $339,634. The cost per individual served was $3,575. Graduation was defined as having completed 11 of the 14 sessions; one-on-one meetings could substitute for group

sessions if the purpose was to go over the curriculum. Twenty-five of the ninety-five participants graduated. The cost per graduate was $13,585.

Strengthening Families Cost/Benefit FY 2017/18	
Program Costs	$339,634
Unduplicated individuals served	95
Cost per individual served	*$3,575*
Total Family Members Graduated	25
Cost per graduate	*$13,585*

Access and Linkage to Treatment Strategy
The Family Therapy for Children and Youth program made no referrals to treatment in Fiscal Year 2017/18.

Timely Access to Services for Underserved Populations Strategy[14]
The Family Therapy for Children and Youth program made no referrals of underserved populations to PEI or behavioral health treatment.

Encouraging Access to Services and Follow Through
The following are ways that SJCBHS and Family Therapy for Children and Youth program encourage access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.
- Program accepts referrals year-round and keeps a waiting list for families who are unable to join the current group cycle.
- The program offers adjunctive services to families who qualify for our program, but are unable to join group sessions on Tuesday evenings.

[14] San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations.

Recovery Services for Victims of Human Trafficking

Project Description

The Recovery Services for Victims of Human Trafficking program launched in the third quarter of Fiscal Year 2017/18. Women's Center Youth and Family Services identify and provide mental health treatment to victims of human trafficking and other exploitation. The project involves outreach, screenings, resource navigation, case management and short-term clinical interventions.

Project Outputs

The program engaged in 12 outreach events reaching a total of 635 participants

Recovery Services for Victims for Human Trafficking Output: FY 2017/18	
Number of Outreach Events	12
Number of Individuals Reached via Outreach	635
Number of Individuals Newly Enrolled	19
Number of Participating Family Members	1
Number of Individuals who Participated in Case Management Services	12
Number of Minutes of Case Management Services Provided	2665
Number of Minutes of Case Management Services Provided Per Individual	222
Number of Individuals offered clinical interventions	0
Number of Individuals who received clinical interventions	0

Participant Demographics

Demographics were collected for all 19 participants. The majority were between 25-59 years old (63%), 26% were TAY and 11% were children, under age 18. Forty-one percent (41%) identified as White, 21% as Latino/Hispanic and 16% as African American or Black. Spanish was the primary language for 5% of the participants. Nearly half (47%) identified as heterosexual, but almost as many were placed in the decline to state demographic category. Eighty-nine percent identified as female and 5% as male; the remainder declined to state. Two percent identified as bisexual or questioning. Slightly more than half (53%) lived in Stockton, and the remainder lived in Lodi and Manteca and another location.

Recovery Services for Victims for Human Trafficking Demographics : FY 2017/18		
Unduplicated individuals served	19	
Number of demographic forms collected	19	100%
Ages		
0-15	2	11%
16-25	5	26%
26-59	12	63%
60+	0	0%
Decline to answer	0	0%
Number of children <26 of participants	0	0%
Race		
American Indian or Alaskan Native	1	5%
Asian	0	0%
Black or African American	3	16%
Native Hawaiian or other Pacific Islander	0	0%
White	8	42%
Other	3	16%
More than one race	3	16%
Decline to answer	1	5%
Ethnicity		
Hispanic or Latino as follows:		
Caribbean	0	0%
Central American	0	0%
Mexican/Mexican-American	4	21%
Puerto Rican	0	0%
South American	0	0%
Other	0	0%
Non-Hispanic as follows:		
African	2	11%
Asian Indian/South Asian	0	0%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Other	2	11%
More than one ethnicity	3	16%
Decline to answer	1	5%
Primary Language		
English	18	95%
Spanish	1	5%
Other	0	0%
Decline to answer	0	0%

Sexual Orientation		
Gay or Lesbian	0	0%
Heterosexual or Straight	9	47%
Bisexual	1	5%
Questioning or unsure	1	5%
Queer	0	0%
Another sexual orientation	0	0%
Decline to answer	8	42%
Disability		
Communication - difficulty seeing	0	0%
Communication - difficulty hearing & speech	0	0%
Communication - other	0	0%
Mental disability	2	11%
Physical/mobility disability	0	0%
Chronic health	0	0%
Other	1	5%
No Disability	11	58%
Decline to answer	5	26%
Veteran status		
Yes	0	0%
No	19	100%
Decline to answer	0	0%
Sex assigned at birth	0	
Male	1	5%
Female	18	95%
Decline to answer	0	0%
Current Gender Identity		
Male	1	5%
Female	17	89%
Transgender	0	0%
Genderqueer	0	0%
Questioning or unsure of gender identity	0	0%
Another gender identity	0	0%
Decline to answer	1	5%
Residence		
Stockton	10	53%
Lodi	2	11%
Manteca	3	16%
Tracy	0	0%
Other	4	21%
Decline to answer	0	0%

Participant Outcomes

The program uses the CANSA at intake and discharge to measure participant outcomes. Seven (37%) of participants received an intake CANSA. The first CANSA was administered in May of 2018. No follow up CANSAs were administered by the end of the Fiscal Year.

Cost Benefit Analysis

The Victims of Human Trafficking program served 19 individuals costing $13,236 per individual. No outcomes were measured during the reporting period.

Recovery Services for Victims for Human Trafficking Output: FY 2017/18	2017/18
Program Costs (i.e., $ invoiced by contractor)	$251,476
Unduplicated individuals served	19
Cost per individual served	*$13,236*

Access and Linkage to Treatment Strategy
Recovery Services for Victims of Human Trafficking made no referrals to treatment in Fiscal Year 2017/18.

Timely Access to Services for Underserved Populations Strategy[15]
The program made not referrals to treatment or PEI programs during Fiscal Year 2017/18.

Encouraging Access to Services and Follow Through
The following are ways that SJCBHS and Victims of Human Trafficking program encourages access to services and follow through:

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- WCYFS equips all individuals with education regarding behaviors related to victimizations within our interactions, as well as provide information on available community resources should the individual decide to engage in services.

[15] San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations.

Prevention and Early Intervention Program[16]:

Mental Health Services for High Risk Youth at the Juvenile Justice Center

Program Description

In Fiscal Year 2016/17, the Juvenile Justice Project was delivered by San Joaquin County Behavioral Health Children and Youth Services (CYS). CYS provides behavioral health evaluations and transition services for youth detained at San Joaquin County's Juvenile Justice Center (JJC). Upon detention, JJC administers a MAYSI-II screening. CYS evaluates youth with high- and medium-risk MAYSI-II scores within 24 hours and youth with low-risk scores within 5 days. Regardless of MAYSI-II score, if youth agree to participate in CYS services they receive a comprehensive behavioral health assessment. Youth determined to be SMI/SED receive early intervention-oriented mental health services whereas those who are not SMI/SED receive prevention-oriented services. If youth are detained for 60 days or longer, they receive a followup CANSA assessment, which is used to measure outcomes related to mental status, risk and protective factors.

Project Outputs

In Fiscal Year 2017/18, CYS evaluated 659 (74%) of the 887 youth who were detained at the JJC. Those who were not evaluated were released before CYS staff had an opportunity to meet with them. Of those evaluated, 282 (43%) agreed to a comprehensive mental health assessment. In total CYS conducted 192 assessments. Those who were not assessed were released prior to assessment. Of those assessed, 131 (68%) were diagnosed with SED/SMI and of those, 86 (66%) had at least one intervention service. Of the 61 youth who were not SMI/SED, 27 (44%) received a prevention-oriented mental health service. In total 113 youth received PEI services. Half of those were at the JJC long enough to complete a 60-day CANSA, and of those, 27 (48%) showed improvement.

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[16] The County may combine an Early Intervention Program with a Prevention Program, as long as the requirements in Section 3710 and Section 3720 are met

JJC	2017/18		
Number of detained youth	887		
Number of high-risk youth with MAYSI-II who received evaluation (opened to BHS)	265	30%	of detained youth
Number of low-risk youth MAYSI-II who received evaluation (open to BHS)	394	44%	of detained youth
Number of youth who released from detention prior to evaluation	228	26%	of detained youth
Number evaluated	659	100%	of youth detained long enough for evaluation
Number agreeing to assessment	282	43%	of evaluated youth
Number in custody long enough for assessment	216	77%	of youth agreeng to assessment
Number assessed	192	89%	of youth in custody long enough for an assessment
Number diagnosed with SED/SMI as a result of the assessment	131	68%	of assessed youth
Number who were not diagnosed with SED/SMI as a result of the assessment	61	32%	of assessed youth
Number with SMI/SED who received at least one services	86	66%	of youth dx w/ SED/SMI
Number w/out SMI/SED who received at least one services (prevention) post assessment	27	44%	of youth not dx with SED/SMI
Total receiving PEI services	113	59%	of assessed youth
Number completed matched baseline/60-day CANSA	56	50%	of youth receiving PEI services
Number showing improvements in CANSA scores	27	48%	of youth with matched CANSAS

Participant Demographics

Demographic information was reported for 185 youth, which represents 96% of the 192 youth who received an assessment. Thirty-one percent were under the age of 16 and the remainder were between ages 16-25. Almost half (47%) identified as Hispanic/Latino and 26% as African American or Black. The current gender identify was male for 84% of the participants, and 94% identified as heterosexual.

JJC Demographics FY 2017/18		
Unduplicated individuals served	185	
Number of demographic forms collected	185	
Ages		
0-15	58	31%
16-25	126	68%
26-59	0	0%
60+	0	0%
Decline to answer	1	0.5%
Race		
American Indian or Alaskan Native	0	0%
Asian	4	2.2%
Black or African American	49	26%
Native Hawaiian or other Pacific Islander	2	1.1%
White	33	18%
Other	94	51%
More than one race	3	1.6%
Decline to answer	0	0%
Ethnicity		
Hispanic or Latino as follows*:	87	47%
Non-Hispanic as follows:		
African	0	0%
Asian Indian/South Asian	0	0%
Cambodian	1	1.1%
Chinese	1	1.1%
Eastern European	0	0%
European	2	2.3%
Filipino	1	1.1%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Other	0	0%
More than one ethnicity	15	17%
Decline to answer	79	91%

Primary Language		
English	169	*91%*
Spanish	14	*8%*
Other	2	*1.1%*
Decline to answer	0	*0%*
Sexual Orientation		
Gay or Lesbian	1	*0.5%*
Heterosexual or Straight	174	*94%*
Bisexual	8	*4%*
Questioning or unsure	0	*0%*
Queer	0	*0%*
Another sexual orientation	0	*0%*
Decline to answer	2	*1.1%*
Disability		
Communication - difficulty seeing	24	*13%*
Communication - difficulty hearing & speech	3	*1.6%*
Communication - other	0	*0%*
Mental disability	0	*0%*
Physical/mobility disability	0	*0%*
Chronic health	0	*0%*
Other	1	*0.5%*
Decline to answer	101	*55%*
Sex assigned at birth		
Male	156	*84%*
Female	29	*16%*
Decline to answer	0	*0%*
Current Gender identity		
Male	155	*84%*
Female	30	*16%*
Transgender	0	*0%*
Genderqueer	0	*0%*
Questioning or unsure of gender identity	0	*0%*
Another gender identity	0	*0%*
Decline to answer	0	*0%*
Residence		
Stockton	56	*30%*
Lodi	6	*3%*
Manteca	7	*4%*
Tracy	10	*5%*
Other	106	*57%*
Decline to answer	0	*0%*

**Specific Hispanic/Latino Ethnicity Information Not Collected*

Participant Outcomes

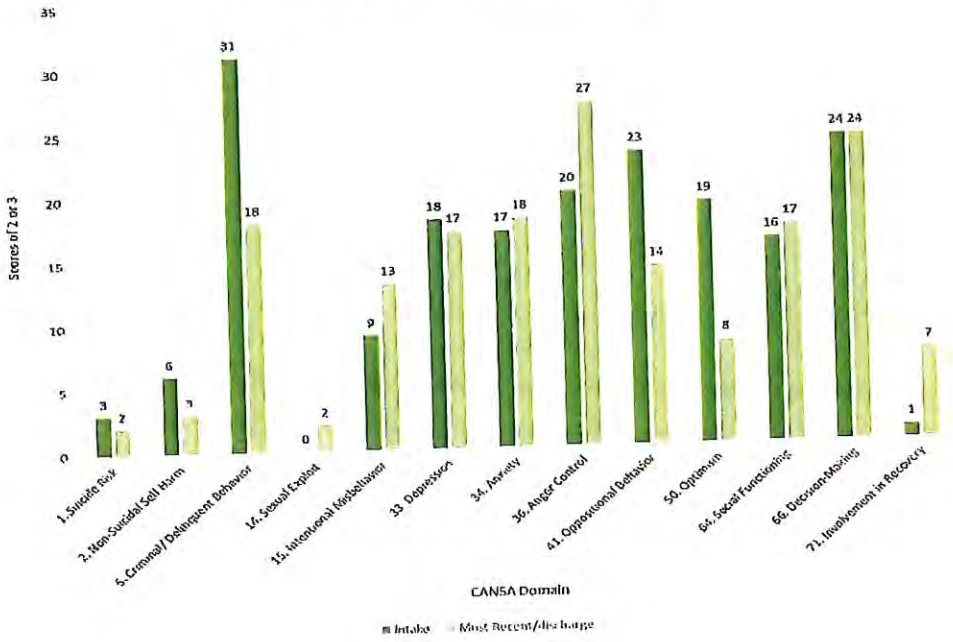
In Fiscal Year 2017/18, for those who were detained at the JJC long enough to receive a matched intake and 60-day CANSA (n-58), 41% demonstrated an overall reduction in CANSA scores for the 13 selected items.

JJC CANSA	2017/18
Number of participants w/ matched scores	58
Number of matched assessments that demonstrate improvement (decrease in total score)	24
Percent of matched assessments that demonstrate improvement (decrease in total score)	41%
Average pre score	10.6
Standard deviation	4.7
Average Post score	10.9
Standard deviation	5

The table below demonstrates the number of youth who had actionable items (scores of 2 and 3) in each of the selected CANSA items at intake and 60-day reassessment. The areas of greatest concern at intake were in criminogenic/ delinquent behavior, decision-making, oppositional behaviors, and anger control. The greatest improvements were made in criminogenic/delinquent behaviors, optimism, oppositional behaviors, suicide risk and non-suicidal self-harm. Increases in scores were observed in sexual exploitation (presumably as a result of later disclosure), intentional misbehavior, anger control, anxiety, and involvement in recovery.

FY 17/18 Juvenile Justice Center PEI Program
Number of Youth with Actionable* CANSA Scores at Intake and Discharge
Total number of matched scores = 58

** Scores of 2 and 3 are considered actionable*



Cost Benefit Analysis

In Fiscal Year 2017/18, program costs included $676,575 from PEI allocations and the remainder from Medi-Cal FFP and other sources. The total cost was $931,424. The cost per youth who received an evaluation was $1,413. The cost per youth who received an assessment was $4,851, and the cost per individual who received a prevention or intervention service was $8,233.

JJC Cost/Benefit	2017/18
Program Costs*	$931,424
Number of individuals evaluated	659
Cost per individual evaluated	$1,413.39
Number of individuals assessed	192
Cost per individual served	$4,851
Number of individuals who received at least one PEI service	113
Cost per individual who received at least one PEI service	*$8,243*

* $676, 575 from PEI

Project Referrals to Treatment:
During Fiscal Year 2016/17, SJCBHS developed data systems to comply with state regulations.

In Fiscal Year 2017/18, 99 individuals were referred to treatment, and 14 engaged in treatment. The average interval between referral and initiation of treatment was 154.7 days (SD 122.3 days). Data related to duration of mental illness were not collected Detailed referral demographic data are included in the supplemental spreadsheets.

Access and Linkage to Treatment Strategy	
Number of individuals referred to tx in FY 17/18	99
Number of identified individuals who engaged in tx	14
Average interval in days b/w referral and tx	154.7
Standard deviation	122.3

Timely Access to Services for Underserved Populations Strategy[17]
The following is a summary of data on referrals to treatment and PEI programs for underserved populations. We found that 7% of the 126 referred TAYs received treatment; 10% of the 87 referred Latino/Hispanic youth; 0% of the 4 Asian youth; 10%

[17] San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking.

of Black or African American youth; 0% of the one Native American youth; and 10% of the LGBTQ youth received treatment.

Timely Access to Services for Underserved Populations	2017/18
Number of underserved individuals (Hispanic) referred to tx or PEI	87
Number who followed through on referral	9
Average interval in days between referral and participation	117.6
Standard deviation	134.7
Number of underserved individuals (Asian) referred to tx or PEI	4
Number who followed through on referral	0
Average interval between referral and participation	n/a
Standard deviation	n/a
Number of underserved individuals (African American) referred to tx or PEI	49
Number who followed through on referral	5
Average interval between referral and participation	256
Standard deviation	53
Number of underserved individuals (Native American) referred to tx or PEI	1
Number who followed through on referral	0
Average interval between referral and participation	n/a
Standard deviation	n/a
Number of underserved individuals (TAY) referred to tx or PEI	126
Number who followed through on referral	9
Average interval between referral and participation	183.9
Standard deviation	123.3
Number of underserved individuals (Older Adult) referred to tx or PEI	0
Number who followed through on referral	n/a
Average interval between referral and participation	n/a
Standard deviation	n/a
Number of underserved individuals (Homeless) referred to tx or PEI	0
Number who followed through on referral	n/a
Average interval between referral and participation	n/a
Standard deviation	n/a
Number of underserved individuals (Veterans) referred to tx or PEI	0
Number who followed through on referral	n/a
Average interval between referral and participation	n/a
Standard deviation	n/a
Number of underserved individuals (LGBTQ) referred to tx or PEI	10
Number who followed through on referral	1
Average interval between referral and participation	45
Standard deviation	n/a
Number of underserved individuals (Non English) referred to tx or PEI	16
Number who followed through on referral	2
Average interval between referral and participation	43.5
Standard deviation	12

Encouraging access to services and follow through

The following are ways in which SJCBHS and the Juvenile Justice Center program encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- A representative from the Victor Community Support Services Juvenile Justice Assessment Treatment Team (JJAT) went to the JJC to provide community-based MH services to youth. They shared information about their program, and JJC implemented a referral process to encourage access to their services.

- The JJC team attends presumptive transfer CFT's at JJC to ensure youth who leave our county continue to receive appropriate mental health services.

- All discharges are reviewed by the JJC Supervisor to ensure linkage to ongoing services were offered to the youth.

- JJC staff arrange for TAY Mentoring providers to start services at JJC prior to the youth discharging in order to build a relationship with the youth. In fiscal year 17/18, JJC referred 27 youth to TAY Mentoring.

Stigma and Discrimination Reduction Programs[18]

NAMI Community Trainings

Description:
Community Trainings to reduce stigma and discrimination are provided by NAMI volunteers throughout San Joaquin County.

Project Outputs:
A total of 1,776 individuals were reached through the Stigma and Discrimination Reduction Project during the 2-year reporting period. The following table shows the type and number of each training/workshop offered and the number of individuals reached.

NAMI Stigma Reduction Output		2016/17		2017/18		Total	
		Number of trainings/ workshops	Number of individuals reached	Number of trainings/ workshops	Number of individuals reached	Number of trainings/ workshops	Number of individuals reached
In Our Own Voice (IOOV)	60-90 minute presentations by two trained speakers describing personal experiences living with mental health challenges and achieving recovery	55	987	33	641	88	1628
Family to Family (F2F)	12-session educational program for family members of adults living with mental illness taught by trained teachers who are also family members.	2	39	2	27	4	66
Peer to Peer (P2P)	10-session class to help adults living with mental illness challenges achieve and maintain wellness taught by Peer Mentors living in recovery	2	27	2	30	4	57
NAMI Basics	6-session class for parents and caregivers of children and adolescents living with mental illness	1	14	1	11	2	25

Participant Outcomes
Following each presentation or series of classes, NAMI facilitators distributed evaluation forms with a set of retrospective Likert Scale items asking participants to rate the degree to which they agreed with certain statements. IOOV and F2F used one set of statements whereas P2P and Basics used a different set of questions. These statements were then distributed into two reporting categories identified by State regulations, namely, number of participants who showed positive change in attitudes, knowledge

[18] **Stigma and Discrimination Reduction Program** are activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. Examples of Stigma and Discrimination Reduction Programs include social marketing campaigns, speakers' bureaus, anti-stigma advocacy, targeted education and trainings, etc. (California Code of Regulations §3725)

and/or behavior related to *mental illness*; and number who sowed positive change in attitudes, knowledge and/or behavior related to *seeking mental health services.* Our analysis demonstrated that taking a weighted average of those participants who "agreed" or "strongly agreed" with each statement, 663 individuals (78%) showed positive change in statements related to mental illness and 717.5 (85%) showed positive change in statements related to seeking mental health services.

Nami Stigma Reduction Total for FY 2016/17 and FY 2017/18				
Because of the class or presentation....		# of survey responses Total	# who "agreed" or "strongly agreed" Total	%
Items included in IOOV & F2F Survey	A: I am comfortable with the idea of working with someone who has a mental illness	784	625	80%
	B: I do not believe mental illness is anyone's fault	805	622	77%
	C: Recovery from Mental Illness is possible	784	662	84%
	D: Individuals have a right and an obligation to actively engage and question their treatment provider	805	696	86%
Items included in P2P & NAMI Basics survey	A: I am better able to recognize the signs and symptoms of mental illness	41	40	98%
	B: I am able to manage the stresses and negative impacts that the stigma of mental illness may cause	41	39	95%
	C: I am better able to understand the type of services people with mental illness need.	41	38	93%
	D: I am able to access the care and support servcies that I or my family members need	41	39	95%
Number of responses that showed positive change in attitudes, knowledge and/or behavior of items *related to mental illness* (Items A&B, avove)			663	78%
Number of responses that showed positive change in attitudes, knowledge and/or behavior of items*related to seeking mental health services* (Items C &D, above)			717.5	85%

Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy

The Stigma and Discrimination Reduction Project also involved an Outreach for Increasing Recognition of Early Signs of Mental Illness strategy. Potential responders were defined as those facilitating or teaching the presentations and classes. Since these classes focused primarily on stigma and discrimination, the class participants were not specifically trained as potential responders. During the reporting period there were 20 presenters in fiscal year 2016/17 and 10 in fiscal year 2017/18. We were unable to determine the total number of trainers across the reporting period because some of the trainers rolled over from the previous year. The following is a demographic breakdown potential responders. Eighty percent (80%) of facilitators were adults; the remainder were older adults. Fifty-seven (57%) percent identified as white and 50% as European, 97% spoke English as their primary language, 73% identified as heterosexual, 47%

reported having a mental disability, none reported being veterans, 73% were female and 60% lived in Stockton. All potential responders were either consumers and/or family members of mental health consumers.

Potential responders were engaged (i.e., presentations/classes were delivered) in the following settings: During the reporting period, most Stigma and Discrimination reduction trainings were held in behavioral healthcare provider offices. Others were held in schools and universities. A smaller number where held in residential substance abuse treatment centers. The target population for Stigma and Discrimination Reduction trainings were principally consumers and/or family members.

NAMI Stigma Reduction Outcome			
Strategy - Outreach for Increasing Recognition of Early Signs of Mental Illness	**2016/17**	**2017/18**	**Total**
Settings in which potential responders were engaged			
Family resource centers	1	0	1
Schools/Universities	13	7	20
Cultural organizations	3	0	3
Primary heatlh care or health clinics	2	2	4
Libraries	1	0	1
Support groups	1	0	1
Shelters	3	0	3
Behavioral healthcare provider offices	30	26	56
Residential Substance Abuse Treatment Center	6	1	7
Churches or Faith-based organizations	0	1	1
Other	0	1	1
Total	60	38	98
Classes/Presentations targeted the following types of participants	**2016/17**	**2017/18**	**Total**
General Public	2	0	2
Medical Providers	0	1	1
Behavioral Health Providers	2	0	2
Other social service providers	2	1	3
Active Military or Veteran	2	0	2
Consumers and/or family members	41	29	70
College and univeristy students	11	5	16
Other	0	2	2
Total	60	38	98

Cost Benefit Analysis

The cost benefit analysis uses the total invoiced costs for NAMI's Stigma and Discrimination project and Outreach for Increasing Recognition of Early Signs of Mental Illness project because NAMI costs were not entirely broken out by program type. Over a two year program, NAMI invoiced $70,000 and trained 2945 individuals. The total cost per individual trained who received training was $24.

Cost Benefit Analysis for Stigma & Discrimination and Outreach Programs			
	Fiscal Year 2016/17	Fiscal Year 2017/18	2-Year Total
Total Costs (invoiced)	$35,000	$35,000	$70,000
Total number of individuals trained	1102	1843	2945
Cost per individual trained	$32	$19	$24

Access and Linkage to Treatment Strategy
The Stigma and Discrimination Reduction Project made no referrals to treatment in Fiscal Years 2016/17 or 2017/18.

Timely Access to Services for Underserved Populations Strategy
The Stigma and Discrimination Reduction Project made no referrals to treatment or PEI programs in Fiscal Years 2016/17 or 2017/18.

Encouraging access To services and follow through
The following are ways in which SJCBHS and the Stigma and Discrimination Project encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- NAMI teachers/facilitators announce and promote SJCBHS services in all classes and presentations.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program[19]:

NAMI Community Trainings

Project Description

During the 2-year reporting period, Outreach for Increasing Recognition of Early Signs of Mental Illness was delivered by National Alliance on Mental Illness San Joaquin (NAMI). NAMI also offered Parents and Teachers as Allies Courses as part of this project but was unsuccessful attracting participants.

Project Outputs

During the two-year reporting period, NAMI delivered a total of four (4) 15-hour Provider Education classes to 67 individuals. The settings in which potential responders engaged (i.e., classes were held) included behavioral healthcare offices and at and independent living center. The types of responders engaged in both settings all identified as behavioral health providers.

Potential Responders Demographics

Potential Responders are comprised of trainers and individuals trained in NAMI's Provide Education. Because some of the trainers rolled over from Fiscal Year 2016/17 to 2018/19, there was no way to determine an unduplicated 2-year count, so demographics are presented for each year below. For each fiscal year, responders were mostly between the ages of 26-59, predominantly White and Hispanic/Latino and English-speaking. Most identified as heterosexual, and a large proportion were women and from Stockton.

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[19] All MHPs must have an **Outreach for Increasing Recognition of Early Signs of a Mental Illness Program** and may include an outreach strategy as part of other PEI programs: Outreach is the process of engaging, encouraging, educating, training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. "Potential Responders" includes families, primary care providers, school personnel, community service providers, peer providers, law enforcement personnel, etc. (California Code of Regulations § 3715)

Potential Responders	2016/ 17	2017/18
Total number of potential responders	38	42
Number of demographic forms collected	19	42
Ages		
0-15	0	0
16-25	1	5
26-59	17	31
60+	1	4
Decline to answer	0	2
Race		
American Indian or Alaskan Native	0	0
Asian	0	7
Black or African American	3	8
Native Hawaiian or other Pacific Islander		0
White	11	16
Other	1	6
More than one race	4	5
Decline to answer	0	0
Ethnicity (not reliably collected in FY16/17)		
Hispanic or Latino as follows:		
Caribbean		0
Central America		0
Mexican/Mexican-American		11
Puerto Rican		0
South American		0
Other		21
Non-Hispanic as follows:		
African		4
Asian Indian/South Asian		0
Cambodian		1
Chinese		0
Eastern European		0
European		5
Filipino		1
Japanese		0
Korean		0
Middle Eastern		1
Vietnamese		1
Other		2
More than one ethnicity		5
Decline to answer		17
Primary Language		
English	15	35
Spanish	4	5
Other	0	1
Decline to answer	0	1

Potential Responders	2016/ 17	2017/18
Sexual Orientation		
Gay or Lesbian	0	2
Heterosexual or Straight	14	32
Bisexual	2	1
Questioning or unsure	0	0
Queer	0	0
Another sexual orientation	1	1
Decline to answer	2	6
Disability		
Communication - difficulty seeing	2	2
Communication - difficulty hearing & speech	0	0
Communication - other	0	0
Mental disability	8	6
Physical/mobility disability	5	5
Chronic health	4	3
Other	1	1
Decline to answer	4	23
Veteran status		
Yes	0	2
No	19	35
Decline to answer	0	5
Gender assigned at birth		
Male	6	6
Female	13	32
Decline to answer	0	4
Current Gender Identity		
Male	6	6
Female	12	32
Transgender	0	1
Genderqueer	0	0
Questioning or unsure of gender identity	0	0
Another gender identity	0	0
Decline to answer	1	3
Residence		
Stockton	14	29
Lodi	2	2
Manteca	1	4
Tracy	1	1
Other	1	3
Decline to answer	0	3

Cost Benefit Analysis

The cost benefit analysis for provider education is integrated into the Stigma and Discrimination cost benefit analysis because the costs between the two projects were not easily distinguished.

Access and Linkage to Treatment Strategy

In Fiscal Year 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early Fiscal Year 2016/17, SJCBHS and PEI contractors

developed more comprehensive referral tracking policies, procedures, and data systems, and began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs in 4th quarter. The Outreach for Increasing Recognition Project made no referrals to treatment in Fiscal Year 2016/17 or Fiscal Year 2017/18.

Timely Access to Services for Underserved Populations Strategy[20]
Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- The Stigma and Discrimination Reduction Project made no referrals of underserved populations to PEI or behavioral health treatment.

Encouraging Access to Services and Follow Through
The following are ways in which SJCBHS and the Outreach for Increasing Recognition of Early Signs of Mental Illness Project encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- NAMI teachers/facilitators announce and promote SJCBHS services in all classes and presentations.

[20] San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations.

Suicide Prevention[21]

CAPC Suicide Prevention Program

Project Description

In Fiscal Year 2016/17, the Suicide Prevention Program was delivered in 12 San Joaquin County high schools by Child Abuse Prevention Council of San Joaquin County (CAPC). The program involved the evidence-based Yellow Ribbon (YR) Suicide Education Campaign and ancillary Be a Link Adult Gatekeeper and Ask 4 Help Youth Gatekeeper Trainings. In addition, CAPC provided SafeTALK workshops to youth over age 15 to assist in the recognition of individuals with suicidal thoughts and to connect them to mental health resources. The Suicide Prevention Project also included depression screenings, referrals, and school-based depression support groups.

Project Outputs:

The Suicide Prevention Project reached a total of 12,450 unduplicated individuals during the reporting period. The following table is a detailed breakdown of the number of individuals reached by program activities and fiscal year:

CAPC Suicide Prevention Output FY 2016/17 and FY 2017/18 (some counts are duplicated)	**2016/17**	**2017/18**	**Total**
Total reached	5559	6891	12450
Yellow Ribbon campaign messaging	4891	6017	10908
Depression Screening	323	433	756
Be a Link ® Adult Gatekeeper Training	60	245	305
Ask 4 Help ® Youth Gatekeeper Training	190	223	413
Safetalk Training	107	147	254
CAST Support Groups	32	44	76
Break Free from Depression Support Groups	24	7	31

Participant Demographics

Demographics are reported for participants of all Suicide Prevention activities during the 2-year reporting period. The majority of participants were under the age of 15 (52%) ; 35% between the ages of 16 and 25, and a small proportion (those who were trained in

[21] **Suicide Prevention:** Suicide prevention programs aim to prevent suicide as a consequence of mental illness. Programs may include public and targeted information campaigns, suicide prevention networks, screening programs, suicide prevention hotlines or web-based resources, and training and education.

Be A Link) were over the age of 25. Forty-one percent identified as Hispanic/Latino; 15% Asian, 14% White, 7% African American; and 1.5% Native American. Spanish was the primary language for 17% of the participants. Participants were split fairly evently between those who identified as male and female, with less than one percent identifying with other genders. Five percent identified as bisexual, 2% as gay or lesbian and less than one percent as a sexual orientation other than heterosexual. Aside from Stockton (57%) participants mostly lived in Tracy (17%) and Lodi (13%) .

CAPC Suicide Prevention Demographics FY 2016/17 and FY 2017/18	Total	
Total reached	12450	
Ages		
0-15	6527	52%
16-25	4298	35%
26-59	273	2.2%
60+	36	0.3%
Decline to answer	1384	11%
Race		
American Indian or Alaskan Native	184	1.5%
Asian	1876	15%
Black or African American	877	7%
Native Hawaiian or other Pacific Islander	304	2.4%
White	1796	14%
Other	3508	28%
More than one race	2035	16%
Decline to answer	2005	16%
Ethnicity		
Hispanic or Latino as follows:		
Caribbean	20	0.2%
Central America	291	2.3%
Mexican/Mexican-American	4331	35%
Puerto Rican	76	0.6%
South American	53	0.4%
Other	333	3%
Non-Hispanic as follows:		
African	426	3%
Asian Indian/South Asian	274	2.2%
Cambodian	358	3%
Chinese	138	1.1%
Eastern European	91	0.7%
European	430	3%
Filipino	557	4%
Japanese	69	0.6%
Korean	21	0.2%
Middle Eastern	195	1.6%
Vietnamese	216	1.7%
Other	765	6%
More than one ethnicity	1798	14%
Decline to answer	2130	17%
Primary Language		
English	8050	65%
Spanish	2114	17%
Other	849	7%
Decline to answer	1565	13%

Sexual Orientation		
Gay or Lesbian	239	1.9%
Heterosexual or Straight	8803	71%
Bisexual	594	5%
Questioning or unsure	120	1.0%
Queer	58	0.5%
Another sexual orientation	107	0.9%
Decline to answer	2602	21%
Disability		
Communication - difficulty seeing	885	7%
Communication - difficulty hearing & speech	136	1.1%
Communication - other	0	0.0%
Mental disability	345	3%
Physical/mobility disability	87	0.7%
Chronic health	101	0.8%
Other	178	1.4%
Decline to answer	3127	25%
Veteran status		
Yes	61	0.5%
No	10755	86%
Decline to answer	1706	14%
Sex assigned at birth		
Male	5408	43%
Female	5645	45%
Decline to answer	1466	12%
Current Gender identity		
Male	5286	42%
Female	5498	44%
Transgender	41	0.3%
Genderqueer	26	0.2%
Questioning or unsure of gender identity	40	0.3%
Another gender identity	48	0.4%
Decline to answer	1504	12%
Residence		
Stockton	7065	57%
Lodi	1565	13%
Manteca	50	0.4%
Tracy	2174	17%
Other	206	1.7%
Decline to answer	1460	12%

Participant Outcomes

Retrospective surveys were delivered to all students who attended Yellow Ribbon Presentations over the course of two years. Of the 10,908 who received YR messaging and responded to surveys, 8,281 (76%) reported increased knowledge of warning signs,

risk and protective factors of suicide, and increased understanding of how to ask for help for themselves and others.

Retrospective surveys were also delivered to Adult and Youth Gatekeepers and Safe Talk workshop attendees in Fiscal Year 2016/17 and 2017/18. CAST and BFT group participants received pre post surveys, but insufficient matched responses (n=4) were collected to accurately measure outcomes. The following table illustrates outcomes for the four suicide prevention activities from which sufficient data were collected.

CAPC Suicide Prevention Outcomes FY 2016/17 and FY 2017/18				
Activity	Change Reported	# of surveys collected	# showing improvement	%
Yellow Ribbon campaign messaging	Increase in knowledge of warning signs, risk and protective factors of suicide and increased understanding of how to ask for help for self and others	10908	8281	76%
Be a Link ® Adult Gatekeeper Training	Increase in knowledge of warning signs of suicide, increased understanding of protocols for referring youth to helping resources, and increased knowledge of help resource	305	228	75%
Ask 4 Help ® Youth Gatekeeper Training	Increase in knowledge of warning signs of suicide and depression, increased knowledge of how to respond to those at risk and increased knowledge of local and community referral points and local resources.	413	354	86%
Safetalk Training	Increase in ability to understand the dynamics of suicide, identify people who have thoughts of suicide and apply the TALK steps (Tell, Ask, Listen and Keep Safe).	254	228	90%

Note: insufficient matched pre and post surveys were collected to report outcomes of the school-based Breaking Free from Depression (BFD) and Coping and Support Training (CAST) support groups. A more detailed breakdown of outcomes by Fiscal Year and Program are included in the supplemental file.

Cost Benefit Analysis

The following table shows the cost per unduplicated individual reached by the Suicide Prevention Program as well as the cost per individual who demonstrated improvement. It is important to note that the number who showed improvement is a duplicated count, meaning that some individuals participated in more than one activity.

CAPC - Suicide Prevention Cost/Benefit	2016/17	2017/18	Total
Program Costs	$445,423	$488,725	$934,148
Unduplicated individuals served	5559	6891	12,450
Cost per individual served	*$80.13*	*$70.92*	*$75.03*
Number who showed improvement/positive change	4152	4939	9091
Cost per individual who showed improvement/positive change	*$107.28*	*$98.95*	*$102.76*

Access and Linkage to Treatment Strategy

In Fiscal Year 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. Detailed data with demographic information are provided in a secure confidential Excel file.

- In Fiscal Year 2016/17 CAPC reported having made 319 referrals to for screening, assessment and possible treatment.
- In the 4th quarter of Fiscal Year 2016/17, when we SJCBHS began tracking linkages, a total of 23 individuals identified by the Suicide Prevention were referred to SJCBHS for screening, assessment, and to determine eligibility for treatment.
- Five (5) of these individuals were opened to SJCBHS services for treatment.
- Twenty-one (21) of the 23 individuals provided information on the duration of untreated mental illness. The average duration was 29 months (s = 64.8).
- Of the 5 individuals opened to SJCBHS service, the average duration between referral and treatment for the two for whom we have data was 159.5 days (s = 51.6)
- In Fiscal Year 2017/18 CAPC reported having made 175 referrals to BHS for screening, assessment and possible treatment.
- Twenty (20) of these individuals engaged in treatment.
- Thirteen (13) of the 20 individuals provided information on the duration of untreated mental illness. The average duration was 36 months (s = 38.6).

- Of the 20 individuals opened to services, the average duration between referral and treatment was 65.2 days (s = 48.7)

- Due to the small sample, demographic information on referrals in included in the confidential supplemental file.

Timely Access to Services for Underserved Populations Strategy[22]
Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- In Fiscal Year 2016/17 a total of 17 referrals were made for members of underserved populations (several individuals referred met the criteria for underserved population in two demographic categories)

- Three (3) of the individuals who were members of underserved populations participated in the program to which they were referred.

- In Fiscal Year 2017/18, seventeen (17) of the 20 individuals who received treatment were members of underserved populations (several individuals referred met the criteria for underserved population in two demographic categories)

Encouraging Access to Services and Follow Through
The following are ways in which SJCBHS and the Suicide Prevention Program encourage access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

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[22] San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations.

- As a result of a positive screening, youth are referred to a variety of mental health services, ranging in intensity from group to individual to crisis services. CAPC staff follow up with students 30, 60, and 90 days after a referral is made to ensure they receive the services and support they are in need of and that they are not forgotten about while they navigate the mental health system.

XII. Appendix: Community Planning Documents

- MHSA Public Meeting Flyer
- MHSA Consumer Meeting Flyer
- Community Planning Presentation
- Input and Recommendations Form
- Stakeholder Information Form
- Stakeholder Demographic Form
- Adult Consumer Survey, Summary Results
- Child and Youth Consumer Survey, Summary Results
- Public Hearing Presentation
- Letters Received During 30-Day Public Review and Comment Period

San Joaquin County Behavioral Health Services

Transforming Mental Health Services

Community Planning Meetings
Mental Health Service Act (MHSA)
Annual Update

The Mental Health Services Act (MHSA), intended to transform public mental health care for children, youth, adults and seniors. MHSA provides funding allocations for community mental health services in five program areas:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET)
- Capital Facilities and Technological Needs (CF/TN)
- Innovation (INN)

Please join us at one of the following community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include an update on how MHSA funds are currently being used, as well as a chance to share your opinion and recommendations on how to expand or enhance programs and services. Your feedback is needed to inform next year's 2019-20 Program and Expenditure Plan.

We are counting on your voice to help guide us!

Monday November 5, 2018	Wednesday November 7, 2018	Thursday November 8, 2018	Wednesday November 14, 2018
3:30 – 5:30 pm	3:00 – 5:00 pm	4:00 – 6:00 pm	5:00 – 7:00 pm
Community Stakeholder Meeting at BHS 1212 N. California St. Conference Room A&B Stockton CA 95202	**Meeting at Larch Clover Community Center** Larch Clover 11157 W. Larch Rd. Tracy CA 95304	**Meeting at Lodi Library** Lodi Library 201 W. Locust St. Lodi CA 95240	**Behavioral Health Board Meeting at BHS** 1212 N. California St. Conference Room A&B Stockton CA 95202

Meeting accessibility is important. Please contact us at 209-468-8750 to discuss accessibility questions. All meetings are held in accessible locations. Translation assistance is available upon request. Families are welcome.

Please post this notice in a public location and distribute via your mailing lists.
Thank you for passing this invitation along.

San Joaquin County Behavioral Health Services

Transforming Mental Health Services

Community Planning Meetings
Mental Health Service Act (MHSA)
Annual Update

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We are counting on your voice to help guide us!

Thursday November 8	Thursday November 15
10:00am – 12:00pm	10:00am – 12:00pm
The Wellness Center	**Martin Gipson Socialization Center**
1109 N. California St. Stockton CA 95202	405 E. Pine Street Stockton, CA 95204

Meeting accessibility is important. Please contact us at 209-468-8750 to discuss accessibility questions. All meetings are held in accessible locations. Translation assistance is available upon request. Families are welcome.

Please post this notice in a public location and distribute via your mailing lists.
Thank you for passing this invitation along.

SAN JOAQUIN
COUNTY
Greatness grows here.

San Joaquin County Behavioral Health Services
Mental Health Services Act - Overview

Kayce Rane

Community Program Planning for Fiscal Year 2019-20

Part 1: Overview of BHS

WELCOME AND INTRODUCTIONS
BHS MISSION, VISION, AND VALUES
APPROACH TO SERVICES

Mission and Vision

Mission Statement

- The mission of San Joaquin County Behavioral Health Services is to partner with the community to provide integrated, culturally and linguistically competent mental health and substance abuse services to meet the prevention, intervention, treatment, and recovery needs of San Joaquin County residents.

Vision Statement

- The vision of San Joaquin County Behavioral Health Services is to collaborate as a resilient team exploring changes, sharing ideas, striving to empower consumers, families, volunteers and care providers toward building hope, addressing disparities, and fostering wellness and recovery through individual strength-based treatment.

Core Values

SERVICE:

We are dedicated to serving our community through the promotion of behavioral health and wellness.

RESPECT:

We value diverse experiences, beliefs, and backgrounds and strive in our interactions to keep everyone's dignity intact.

RECOVERY:

We share a belief that all individuals can find a path towards health and well-being.

INTEGRITY:

Our values guide us as individuals and as an organization to be responsive and trustworthy.

Providing our clients with the same quality of care that we all would want our families to receive.

BHS Strategic Priorities

- Increase Access to Services
- Integrate Primary and Behavioral Health Care
- Reduce Justice Involvement
- Ensure Housing Stability

Mental Health Services Continuum of Care:

- Adult Treatment Services
- Children and Youth Services
- Justice / Decriminalization
- 24-Hour Crisis Services
- Administrative Services

SAN JOAQUIN COUNTY

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Service Entry: No Wrong Door

Timely screening and assessments are critical to accessing services.

BHS has embedded clinicians within numerous agencies.

Others have direct access lines to request on-site screening and assessments.

Transportation is provided as needed for further assessment.

SAN JOAQUIN COUNTY

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Part 2: Mental Health Services Act

OVERVIEW OF MHSA
COMMUNITY INVESTMENT
NEW MHSA PROGRAMS

Mental Health Services Act (MHSA

Purpose of MHSA Funding

- Expand and enhance mental health services for individuals with serious mental illness.
- Provide prevention and early intervention services for those at risk of developing a mental illness.
- Promote innovative solutions that will advance the field of mental health.
- Strengthen the personnel, technology, and facilities through which services are offered.

Common Acronyms

(MHSA) Mental Health Services Act, Prop. 63

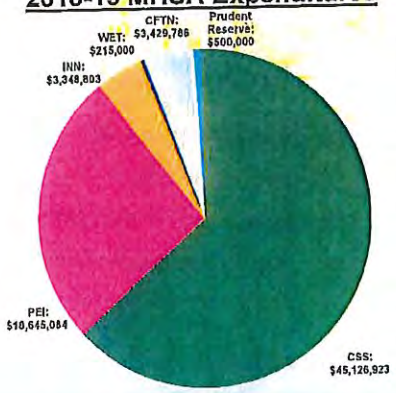
(CSS) Community Services and Supports
(PEI) Prevention and Early Intervention
(INN) Innovation
(WET) Workforce Education and Technology
(CFTN) Capital Facilities and Technology

MHSA Programming in San Joaquin County

Program Areas

- Community Services and Supports
- Prevention and Early Intervention
- Innovative Programs
- Workforce Education and Training
- Capital Facilities and Technology Needs

2018-19 MHSA Expenditures



27% of CSS Expenditures are from Leveraged Funds

SAN JOAQUIN COUNTY

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Building Community Through the MHSA

- 25% of MHSA funded direct program services are provided by contracted community partners.
- 10% of MHSA funds are being used to expand housing and acute care services for the mentally ill.

Cranes Landing Apartments
Eden Housing Management, Inc.
80 Senior Units
Lodi, CA 95242
Phone: (209) 400-2070
8 Units reserved for MHSA Clients

Zettie Miller's Haven
Buckingham Property Management
82-units
Stockton, CA 95207
Office: (209) 475-9827
20 units reserved for MHSA clients.

SAN JOAQUIN COUNTY

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Community Program Planning

Purpose: *To assess the mental health needs of the entire community, including those that are currently served, and those that are unserved, underserved, or inappropriately served.*

Feedback Requested:

1) What is working?
2) What needs improvement?
3) Identify key needs and concerns by age groups.
4) Prioritize needs or concerns.

Definitions:

Gap or Need – Services do not exist, or does not exist for a specific population.

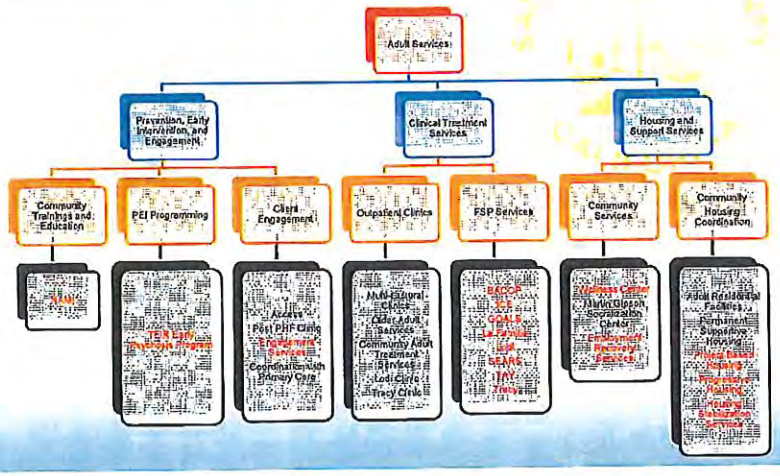
Issue or Concern – Services exist, but there is an issue or concern to be addressed.

Part 3: Continuum of Care as of October 2018

UNIT

ADULT OUTPATIENT SERVICES
CHILDREN AND YOUTH SERVICES
JUSTICE DECRIMINALIZATION & HOMELESSNESS
24-HOUR CRISIS SERVICES

Adult Outpatient Services



Committed to Cultural Competency

Respectful Services for a Diverse Community

- Black Awareness Community Outreach Program
- South East Asian Recovery Services
- La Familia
- Gaining Older Adult Life Skills
- TAY Recovery

Adult Outpatient Clinics operate in six locations throughout the County. Transportation assistance is available for qualified consumers.

- Languages
  - Spanish
  - Tagalog
  - Cambodian
  - Hmong
  - Vietnamese
  - Cantonese

BHS also uses the Health Care Interpreter Network and Language Line Solutions to ensure timely and appropriate access to interpreter services

Consumer Partnerships

NAMI Peer Advocate

Family Advocate

Stakeholder Consortium

Consumer Advisory Council

Grievance Committee

Quality Committee

Cultural Competency Committees

- New Cultural Competency Policy Adopted Dec. 2017
- 96% of mental health providers completed one or more hours of cultural competency training.

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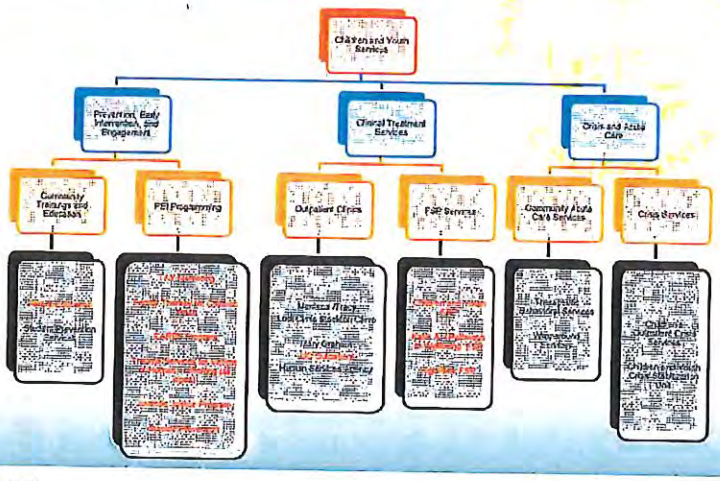
Children and Youth Services



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Children and Youth Services

CYS provides professional therapeutic services that are:

- Child Centered
- Family Focused
- Strength Based
- Culturally Competent and Responsive
- Committed to the values of Recovery and Resiliency

"You might want to quit or think some of this is stupid, but don't quit as it really helped me and my mom to communicate and understand each other better" –youth participant

With two CYS outpatient clinics and treatment programming at:

- Homes
- Schools
- Community Based Organizations
- And wherever youth are at!

Embedded Clinicians at:

- Juvenile Detention Facility
- Child Protective Services
- Mary Graham Children's Shelter

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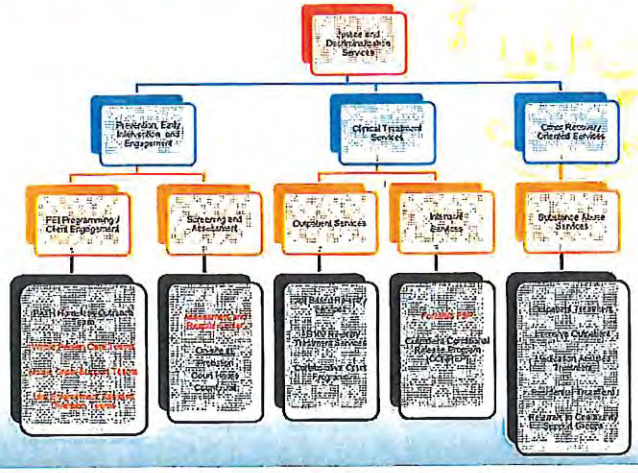
Justice Decriminalization & Homelessness



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Mobile Crisis Support Teams

Team Composition:

- Mental Health Clinician
- Mental Health Outreach Worker

Six Teams:

- North County
- South County
- Children's Team
- Justice Team
- Stockton Team 1
- Stockton Team 2

Homeless Outreach

PATH

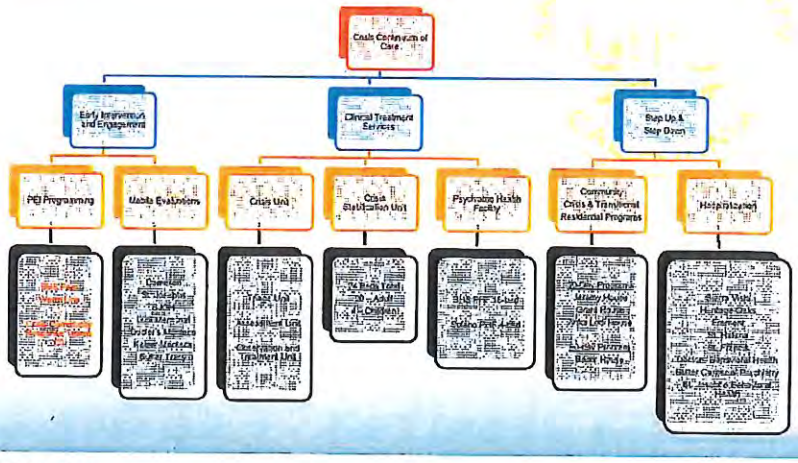
Whole Person Care

Law Enforcement Assisted Diversion

Partner Capacity Building

- Probation Officers and Custody Division Officers are trained in Motivational Interviewing.
- Stockton Police Department is implementing the Memphis Model, Crisis Intervention Team with five officers completing 40 hour certification course in training for CIT.

Crisis Continuum of Care



Peer Crisis Support

Peer support to prevent the escalation of a mental health crisis.

Each Month...

- 1,600 warm line calls
- 100 follow up calls
- 400 voluntary transports to Crisis Services

24-Hour Crisis Services

- **Psychiatric Health Facility: 16 beds**
- **Crisis Stabilization Unit: 20 beds**
- **Children and Youth CSU: 4 beds**
- **Contracted PHF Beds: 4 beds**
- **Crisis Residential Treatment Programs**
  - Jeremy House – 6 beds
  - Anka Lodi – 16 beds
  - Grant House – 15 beds
- **Transitional Social Rehabilitation Program**
  - Bright House – 15 beds

Triage and Assessment

24-Hour Crisis Unit

CMC Assessment and Respite Center

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Additional System Improvements

Improving Data Dashboards

Refining Electronic Health Records

Strengthening Workforce

Data Driven Improvement

- Quarterly Program Progress Reports
- Annual Program Evaluation

Updating Facilities

- Improved Signage
- Updated Emergency Back-up Systems
- Reserved Parking for Consumers

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New and Expanded MHSA Programs

2017 New and Expanded Programs

- Family Therapy for Youth
- Recovery Services for Victims of Human Trafficking
- Whole Person Care Pilot Project
- Project Based Housing
- Progressive Housing
- Assessment and Respite Center (CMC Assessment Center)

Program Operations have Begun

2018 New and Expanded Programs

- Mobile Crisis Support Team Expansion
- Law Enforcement Assisted Diversion
- Intensive Adult FSP
- Intensive Justice Response FSP
- School-based Interventions for Children and Youth
- Adult Residential Care Facility
- High Risk Transition Team
- Peer Navigation
- PEI Trauma Services for Adults
- Forensic Access & Engagement for Repeat Court Offenders

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Part 4: Planning Discussion

GROUP BRAINSTORM
- What works?
- What needs improvement?

SMALL GROUP DISCUSSION

PRIORITIZATION

SAN JOAQUIN COUNTY

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Instructions for Discussions

1. Group Brainstorm:

- Think about the following questions, and complete page 1 of handout.
  - What is working?
  - What needs improvement?
- Share your ideas in the large group discussion.

2. Small Group Discussion:

- Introduce yourselves to the others at your table.
- Talk about the issues raised, complete page 2 of handout.
  - Identify key needs and concerns by age group.
  - Identify type of issue or concern
  - Identify population with the greatest needs

3. Report-outs and Prioritization

- Group spokesperson reviews needs or concerns discussed
- Common themes and priorities are identified

SAN JOAQUIN COUNTY

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Planning Activities for this Annual Update

- MHSA Showcase
- Community Planning Meetings
- Consumer Discussion Groups
- Stakeholder Surveys
- Key Informant Interviews
- MHSA Consortium
- Behavioral Health Board
- Draft Plan for 30-day Public Review (March or April)
- Public Hearing (April or May)
- Presentation to the Board of Supervisors (May or June)

SAN JOAQUIN COUNTY

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Collecting your Feedback!

- **Please make sure to:**
  - Sign-in to the meeting.
  - Complete a green demographic form.
  - Submit the confidential stakeholder feedback form.
  - Use the yellow form to tell us what you thought of today's meeting.
  - Consider sending additional feedback, suggestions or ideas to:

Mail:

MHSA Comments
c/o MHSA Coordinator
1212 N. California St.
Stockton CA 95202

E-mail:

mhsacomments@sjcbhs.org

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Kayce Rane
Rane Community Development
kaycerane@ranecd.com

SAN JOAQUIN COUNTY

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San Joaquin County Mental Health Services Act (MHSA) Community Program Planning Process
2018-19 Stakeholder Input and Recommendation Form

Section I. Prevention and Early Intervention (PEI)

1. Based on the summary of PEI Activities and Services, how well do you think programming is responding to the prevention and early intervention needs of the community?

2. Based on your knowledge of the community, and understanding of Prevention and Early Intervention programming funds, what issues or challenges should BHS be looking at for further investments?

3. Thinking about the recommendations you have made above, do you have any further thoughts on target populations that we should be addressing? If possible, tell us a little more about this population and why more PEI services are needed.

San Joaquin County Mental Health Services Act (MHSA) Community Program Planning Process
2018-19 Stakeholder Input and Recommendation Form

Section II. Community Services and Supports (CSS)

1. Based on the summary of CSS Services, how well do you think programming is responding to the treatment needs of people with serious mental illnesses?

2. Based on your knowledge of the needs experienced by people with mental illnesses, and understanding of Community Services and Supports programming funds, what treatment or service areas should BHS be looking at for further investments?

3. Thinking about the recommendations you have made above, do you have any further thoughts on target populations that we should be addressing? If possible, tell us a little more about this population and why more CSS services are needed.

Forma de Comentarios:
Planificación de San Joaquín MHSA 2018-19

¿En general, que tan bien a cumplido con sus expectativas esta junta? (Por Favor Marque Uno)

☐ Muy Bien ☐ Bien ☐ Un Poco ☐ Para Nada

¿Que parte de esta junta funciono bien?

¿Como mejoraría usted esta junta?

Forma de Comentarios:
Planificación de San Joaquín MHSA 2018-19

¿En general, que tan bien a cumplido con sus expectativas esta junta? (Por Favor Marque Uno)

☐ Muy Bien ☐ Bien ☐ Un Poco ☐ Para Nada

¿Que parte de esta junta funciono bien?

¿Como mejoraría usted esta junta?

San Joaquin County Behavioral Health Services
MHSA Planning 2018-19

Your feedback, suggestions, and ideas are welcome at any time. We collect feedback to inform current and future planning at any time during the year. Please share your thoughts and ideas with us.

Want more information about BHS or how MHSA funds are being used in San Joaquin County?
Check out our website:

BHS Website: www.sjcbhs.org

San Joaquin County's MHSA Planning: https://www.sjcbhs.org/MHSA/mhsaplan.aspx

Your feedback is valuable! Please let us know what you think by sending us a message:

Mail: MHSA Comments
c/o MHSA Coordinator
1212 N. California St.
Stockton, CA 95202

E-mail: mhsacomments@sjcbhs.org

San Joaquin County Behavioral Health Services
MHSA Planning 2018-19

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1212 N. California St.
Stockton, CA 95202

E-mail: mhsacomments@sjcbhs.org

San Joaquin County
2018-19 Demographics

San Joaquin County Behavioral Health Services
Community Program Planning Process

Per State of California guidelines, we must report demographic information on planning participants. This information will be kept confidential and used for reporting purposes only. You may decline to answer these questions.

☐ I decline to answer the demographic questions

Please indicate your age range:
- ☐ Under 18
- ☐ 18-25
- ☐ 26-59
- ☐ 60 and older

Please indicate your gender:
- ☐ Male
- ☐ Female
- ☐ Transgender

Please indicate the primary language spoken in your home:
- ☐ English
- ☐ Other: _____

Consumer Affiliation (check all that apply)
- ☐ Mental health client/consumer
- ☐ Family member of a mental health consumer

Stakeholder Affiliation (check all that apply)
- ☐ County mental health department staff
- ☐ Substance abuse service provider
- ☐ Community-based/non-profit mental health service provider
- ☐ Community based organization (not mental health service provider)
- ☐ Children and families services
- ☐ K-12 education provider
- ☐ Law enforcement
- ☐ Veteran services
- ☐ Senior services
- ☐ Hospital/ Health care provider
- ☐ Housing or housing services provider
- ☐ Advocate
- ☐ Other: _____

What is your race ethnicity?
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Southeast Asian
- ☐ Other Asian or Pacific Islander
- ☐ American Indian/Native American/First Nations (including Hawaiian and Alaskan Native)
- ☐ Mixed Race: _____
- ☐ Other: _____

Please return to facilitator upon concluding the meeting. The demographic information is confidential. Your name WILL NOT be connected to your response.

[Type text]

San Joaquin County
2018-19 Demographics

San Joaquin County Behavioral Health Services
Proceso de Planificación de Programas Comunitarios

En acuerdo con las directrices del estado de California, debemos reportar información demográfica de participantes del plan. Esta información se mantendrá confidencial y se usara con fines informativos. Usted puede negarse a responder estas preguntas.

☐ Yo me niego a responder estas preguntas demográficas

Por favor indique su rango de edad:
- ☐ Menor de 18
- ☐ 18-25
- ☐ 26-59
- ☐ 60 o mayor

Por favor indique su genero:
- ☐ Masculino
- ☐ Femenino
- ☐ Transgenero

Por favor indique el idioma principal que es hablado en su hogar:
- ☐ Ingles
- ☐ Español
- ☐ Otro: _____

Afiliacion de consumidor (marque todos los que apliquen)
- ☐ Cliente de salud mental/consumidor
- ☐ Familiar de un consumidor de salud mental

Afiliacion de Intereses (marque todas las que aplican)
- ☐ Personal del condado del departamento de salud mental
- ☐ Proveedor de servicios de abuso de sustancias
- ☐ Proveedor de servicios de salud mental comunitarios/ sin fines lucrativos
- ☐ Organizacion comunitaria (no un proveedor de servicios de salud mental)
- ☐ Servicios de niños y familias
- ☐ Proveedor de educacion k-12
- ☐ Orden publico
- ☐ Servicios para Veteranos
- ☐ Servicios para personas mayores
- ☐ Proveedor de Hospital/cuidado de salud
- ☐ Proveedor de vivienda/servicios de vivienda
- ☐ Defensor
- ☐ Otro: _____

¿Cual es su raza etnica?
- ☐ Blanco/Caucasico
- ☐ Negro/Afro-Americano
- ☐ Hispano/Latino
- ☐ Asiatico Sudeste
- ☐ Asiatico o Isleño del Pacifico
- ☐ Indigena Americano/Indio Americano/Primeras Naciones (incluyendo Hawaino y Nativo de Alaska)
- ☐ Raza Mesclada: _____
- ☐ Otro: _____

Por favor regrese al facilitador una vez que haiga concluido la junta. La información demografica es confidencial. Su nombre NO sera conectado a su respuesta.

San Joaquin County Behavioral Health Services (BHS)

2018-19 MHSA Adult Consumer Survey

Q1 Do you identify as someone who is receiving, or who needs, mental health treatment services?

380 (82%) Yes
51 (11%) No
31 (7%) Not Sure

Q2 Do you identify as someone who is receiving, or who needs, substance use disorder services?

135 (30%) Yes
265 (58%) No
53 (12%) Not Sure

Q3 Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon.

	Needs Improvement	Fair	Good	Very Good	Excellent
1. The location our services are provided.	34 (8%)	52 (12%)	125 (28%)	99 (22%)	131 (30%)
2. The information available in flyers, pamphlets, or on our website that describes our services.	25 (6%)	61 (14%)	143 (34%)	86 (20%)	108 (26%)
3. The length of time it takes to get an appointment.	48 (11%)	55 (13%)	123 (28%)	98 (22%)	116 (26%)
4. The types of individual or group interventions that are offered.	42 (10%)	46 (11%)	139 (32%)	88 (20%)	121 (28%)
5. The thoroughness of the services that are provided.	32 (7%)	43 (10%)	133 (31%)	92 (21%)	135 (31%)

Q4 Would you recommend our services to people who need help for a mental health or substance use concern?

377 (85%) Yes
22 (5%) No
45 (10%) Not Sure

Q5 What services or supports need the most improvement and what should BHS do to make them better?

0 (0%)

Q6 Please let us know whether you think that BHS program services are meeting the cultural and linguistic needs of the community

	Yes, Very much so	Yes, Somewhat	No, Not Really	I don't know
1. Lobby and reception areas are friendly and welcoming.	264 (63%)	113 (27%)	18 (4%)	21 (5%)
2. BHS staff members are courteous and professional.	291 (71%)	97 (24%)	15 (4%)	9 (2%)
3. BHS staff members are respectful of your cultural heritage.	304 (73%)	77 (18%)	13 (3%)	23 (6%)
4. BHS staff members explain things in a way you like and understand.	297 (71%)	93 (22%)	20 (5%)	9 (2%)
5. BHS programs are helpful for many different types of people.	285 (70%)	88 (22%)	9 (2%)	27 (7%)

Q7 Have you or a family member ever used BHS interpretation services?

137 (33%) Yes

231 (56%) No, Skip to Question 9

45 (11%) Not Sure, Skip to Question 9

Q8 If you've used BHS interpretation services, how would you describe the quality of the interpretation services? (If you've never used BHS interpretation services, Skip to Question 9)

16 (9%) Needs Improvement

25 (15%) Fair

43 (25%) Good

49 (28%) Very Good

39 (23%) Excellent

On the following questions, please use CAPITAL letters to answer each question. Put one letter in each box.

Q9 What is the MOST important factor that contributes to wellness and recovery?

328 (100%)

Q10 What is the SECOND most important factor that contributes to wellness and recovery?

318 (100%)

Q11 What is the THIRD most important factor that contributes to wellness and recovery?

297 (100%)

BHS works hard to provide culturally appropriate and responsive services regardless of age, gender identity, sexual orientation, language, disability status, race, or ethnicity. In order to track the effectiveness of our efforts, please answer the following optional questions. All surveys are confidential and anonymous.

Q12 Please indicate your age:

9 (2%)	Under 18
41 (11%)	18-25
242 (63%)	26-59
87 (23%)	60 and Older
5 (1%)	Prefer not to Say

Q13 Are you a parent or are you about to be a parent?

207 (55%)	Yes
151 (40%)	No
9 (2%)	Not Sure
10 (3%)	Prefer not to Say

Q14 Please indicate your gender:

160 (42%)	Male
213 (56%)	Female
3 (1%)	Non-Binary
2 (1%)	Transgender
0 (0%)	Other, I Self-Identify as:_____
2 (1%)	Prefer not to Say

Q15 Do you self-identify as someone with a physical or developmental disability?

186 (48%) Yes
169 (44%) No
33 (9%) Prefer not to Say

Q16 Are you a U.S. Military Veteran of the Army, Navy, Marines, Air Force, or Coast Guard?

24 (6%) Yes
365 (92%) No
9 (2%) Prefer not to Say

Q17 Do you self-identify as Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, or Intersex (LGBTQQI)?

40 (11%) Yes
325 (86%) No
14 (4%) Prefer not to say

Q18 Please indicate the language that is most frequently spoken in your home (please choose only one):

273 (75%) English
14 (4%) Spanish
31 (8%) Mon-Khmer, Cambodian
19 (5%) Vietnamese
4 (1%) Tagalog
8 (2%) Lao, Laotian
11 (3%) Hmong-Mien
5 (1%) Other: _____
1 (0%) Prefer not to Say

Q19 What is your race ethnicity?

61 (17%) African American / Black
69 (19%) Asian American
106 (30%) Caucasian / White
63 (18%) Hispanic / Latino
7 (2%) Native American / First Nations (including Hawaiian and Alaskan Native)
43 (12%) Other, I Self-Identify as:_____
9 (3%) Prefer not to Say

Q20 Are you currently homeless or at risk of homelessness?

83 (21%) Yes
293 (76%) No
12 (3%) Prefer not to Say

Q21 In the past three years have you been homeless for more than a year or experienced homelessness more than four times?

93 (25%) Yes
269 (72%) No
13 (3%) Prefer not to Say

Q22 Have you ever been arrested or detained by the police?

151 (40%) Yes
198 (53%) No
25 (7%) Prefer not to Say

Q23 Is there anything else you want to share about what is needed to better support your wellness and recovery?

0 (0%)

Thank you very much for completing this survey!

San Joaquin County Behavioral Health Services (BHS)

2018-19 MHSA Youth or Family Member of Children and Youth Survey

Q1 Do you identify as someone who is coordinating services for a loved one, receiving, or who needs, mental health treatment services?

188 (62%) Yes
88 (29%) No
26 (9%) Not Sure

Q2 Do you identify as someone who is coordinating services for a loved one, receiving, or who needs substance use disorder services?

34 (11%) Yes
254 (82%) No
21 (7%) Not Sure

Q3 Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon.

	Needs Improvement	Fair	Good	Very Good	Excellent
1. The location our services are provided.	8 (3%)	15 (5%)	99 (33%)	69 (23%)	109 (36%)
2. The information available in flyers, pamphlets, or on our website that describes our services.	5 (2%)	26 (9%)	101 (36%)	70 (25%)	75 (27%)
3. The length of time it takes to get an appointment.	11 (4%)	35 (12%)	95 (32%)	71 (24%)	88 (29%)
4. The types of individual or group interventions that are offered.	5 (2%)	15 (5%)	84 (29%)	81 (28%)	100 (35%)
5. The thoroughness of the services that are provided.	5 (2%)	14 (5%)	78 (27%)	74 (25%)	121 (41%)

Q4 Would you recommend our services to people who need help for a mental health or substance use concern?

261 (85%) Yes
10 (3%) No
35 (11%) Not Sure

Q5 What services or supports need the most improvement and what should BHS do to make them better?

0 (0%)

Q6 Please let us know whether you think that BHS program services are meeting the cultural and linguistic needs of the community

	Yes, Very much so	Yes, Somewhat	No, Not Really	I don't know
1. Lobby and reception areas are friendly and welcoming.	157 (53%)	63 (21%)	12 (4%)	65 (22%)
2. BHS staff members are courteous and professional.	227 (75%)	47 (16%)	9 (3%)	20 (7%)
3. BHS staff members are respectful of your cultural heritage.	229 (74%)	44 (14%)	5 (2%)	32 (10%)
4. BHS staff members explain things in a way you like and understand.	225 (74%)	52 (17%)	7 (2%)	22 (7%)
5. BHS programs are helpful for many different types of people.	205 (70%)	44 (15%)	8 (3%)	36 (12%)

Q7 Have you or a family member ever used BHS interpretation services?

34 (11%) Yes

236 (79%) No, Skip to Question 9

27 (9%) Not Sure, Skip to Question 9

Q8 If you've used BHS interpretation services, how would you describe the quality of the interpretation services? (If you've never used BHS interpreation services, Skip to Question 9)

0 (0%) Needs Improvement

5 (8%) Fair

30 (50%) Good

11 (18%) Very Good

14 (23%) Excellent

On the following questions, please use CAPITAL letters to answer each question. Put one letter in each box.

Q9 What is the MOST important factor that contributes to wellness and recovery?

218 (100%)

Q10 What is the SECOND most important factor that contributes to wellness and recovery?

200 (100%)

Q11 What is the THIRD most important factor that contributes to wellness and recovery?

179 (100%)

BHS works hard to provide culturally appropriate and responsive services regardless of age, gender identity, sexual orientation, language, disability status, race, or ethnicity. In order to track the effectiveness of our efforts, please answer the following optional questions about you or the child/family member getting services. All surveys are confidential and anonymous.

Q12 Please indicate your age/the age of your child/family member

13 (5%) 0-5
74 (29%) 6-11
80 (31%) 12-15
44 (17%) 16-21
17 (7%) 22-25
26 (10%) Prefer not to Say

Q13 Are you the parent or guardian of someone getting BHS services?

135 (50%) Yes
124 (46%) No
8 (3%) Not Sure
3 (1%) Prefer not to Say

Q14 Please indicate your gender/the gender of your child/family member

87 (33%) Male
158 (60%) Female
0 (0%) Non-Binary
3 (1%) Transgender
1 (0%) Other, I Self-Identify as:_____
14 (5%) Prefer not to Say

Q15 Do you (or your child/family member) self-identify as someone with a physical or developmental disability?

64 (24%) Yes
188 (70%) No
17 (6%) Prefer not to Say

Q16 Are you (or your child/family member) pregnant or parenting?

37 (14%) Yes
207 (81%) No
2 (1%) Prefer not to Say
10 (4%) Not Applicable

Q17 Do you (or your child/family member) self-identify as Lesbian, Gay, Bisexual, Transgender, Queer/ Questioning, or Intersex (LGBTQQI)?

32 (12%) Yes
226 (82%) No
19 (7%) Prefer not to Say

Q18 Please indicate the language that is most frequently spoken in your home (please choose only one):

199 (78%) English
53 (21%) Spanish
1 (0%) Mon-Khmer, Cambodian
2 (1%) Vietnamese
0 (0%) Tagalog
0 (0%) Lao, Laotian
0 (0%) Hmong-Mien
0 (0%) Other: _____
0 (0%) Prefer not to Say

Q19 What is your (or your child/family member's) race ethnicity?

22 (9%) African American / Black
8 (3%) Asian American
63 (27%) Caucasian / White
124 (53%) Hispanic / Latino
4 (2%) Native American / First Nations (including Hawaiian and Alaskan Native)
6 (3%) Other, I Self-Identify as:_____
9 (4%) Prefer not to Say

Q20 Are you (or your child/family member) currently homeless or at risk of homelessness?

9 (3%) Yes
276 (95%) No
7 (2%) Prefer not to Say

Q21 In the past three years have you (or your child/family member) been homeless for more than a year or experienced homelessness more than four times?

31 (11%) Yes
250 (87%) No
7 (2%) Prefer not to Say

Q22 Have you (or your child/family member) ever been arrested or detained by the police?

40 (14%) Yes
233 (83%) No
9 (3%) Prefer not to Say

Q23 Is there anything else you want to share about what is needed to better support your wellness and recovery, or the wellness and recovery of your child or family member?

0 (0%)

Thank you very much for completing this survey!

SAN JOAQUIN
COUNTY
Greatness grows here.

Public Hearing

Mental Health Services Act, Program Expenditure Plan
Annual Update for Fiscal Year 2019-20
Posted for Public Review April 12, 2019

Mental Health Services Act (MHSA)

Purpose of Funding

- Expand and enhance mental health services for individuals with serious mental illness.
- Provide prevention and early intervention services for those at risk of developing a mental illness.
- Promote innovative solutions that will advance the field of mental health.
- Strengthen the personnel, technology, and facilities through which services are offered.

MHSA Programming in San Joaquin County

Program Areas

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Innovative Programs (INN)
- Workforce Education and Training (WET)
- Capital Facilities and Technology Needs (CFTN)

Community Services & Supports

- Full Service Partnership Programs
- Outreach and Engagement
- System Development

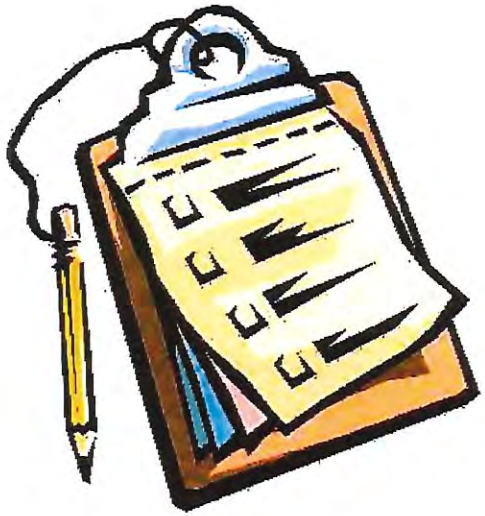
Prevention and Early Interventions

- Prevention
  - Children, Youth, and Families
- Early Intervention
  - Children and Youth
  - Adults and Older Adults
- Reducing Stigma & Discrimination
- Increasing Recognition of Mental Illnesses
- Suicide Prevention
  - Schools
  - Community-wide

SAN JOAQUIN COUNTY

Planning Methodology

- **MHSA Showcase** (Oct.)
- **Public Meetings** (Nov.)
- **Behavioral Health Board** (Nov.)
- **Consumer Discussion Groups** (Nov.)
- **MHSA Consortium Meeting** (Dec.)
- **Consumer Surveys** (Jan.)
  - Adult Consumer Surveys (N=501)
  - Children and Youth Consumer Surveys (N=335)



Community Program Planning

Purpose: *To assess the mental health needs of the entire community, including those that are currently served, and those that are unserved, underserved, or inappropriately served.*

Feedback Requested:

1) What is working?
2) What needs improvement?
3) Identify key needs and concerns by age groups.
4) Prioritize needs or concerns.

Definitions:

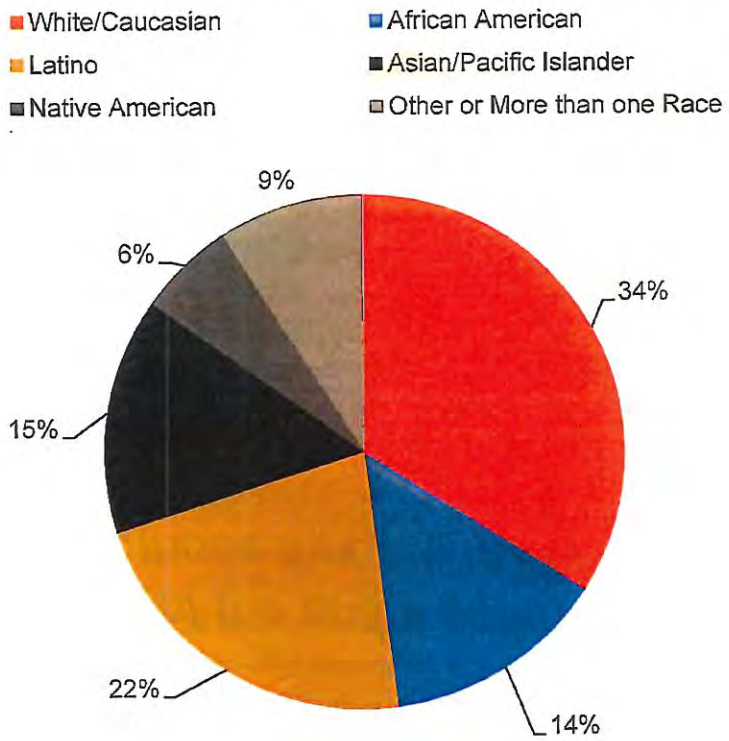
Gap or Need – Services do not exist, or does not exist for a specific population.

Issue or Concern – Services exist, but there is an issue or concern to be addressed.

Stakeholder Participants

- County mental health department staff
- Substance use disorder treatment provider
- Community-based organization staff
- Children and Family Services
- Law Enforcement
- Veterans Services
- Senior Services
- Housing Providers
- Health care Providers
- Advocates for people with Serious Mental Illness

Race/Ethnicity of Community Meeting Participants, Fall 2018



SAN JOAQUIN COUNTY

Summary of Community Input (1)

Children and Youth

- Strengthen coordination with schools and community partners around the provision of services for very vulnerable children, youth, and families.

Transitional Age Youth

- Recognize and target programs towards vulnerable transition age youth, including LGBTQ youth, young veterans, and homeless veterans. Expand coordination with local colleges.

Adults

- Strengthen programs and interventions that address the intersection of mental illnesses, substance use disorders and access to housing.

Summary of Community Input (2)

Older Adults

- Address substance use, homelessness, and suicidality among older adults. Consider more "age-responsive" programs.

General

- Improve distribution of information about mental illnesses and available services. Consider using additional platforms and making information more user friendly with more graphics and in multiple languages.
- Review staff language capacity and address gaps.
- Coordinate with criminal justice and housing partners to (1) reduce incarcerations of mentally ill and (2) reduce homelessness of the mentally ill.

Changes to Plan from Prior Year

- **Increases Workforce Education and Training**
- **Increases Capital Facilities and Technological Needs Funds**
  - Match funds for potential acquisition of a social rehabilitation facility for adults with co-occurring disorders (grant funds)
- **Expands Stigma and Discrimination Reduction Program**
  - Information and Education
- **Expands Suicide Prevention Program**
  - Retains Suicide Prevention in Schools
  - Adds-in community-wide suicide prevention work
- **Eliminates FSP Engagement as a separate project**
  - Most work is folded into other CSS and PEI program activities
  - Has not resulted in a reduction of services for clients

MHSA Funding: Planned Expenditures

Component Area	2018-19	2019-20
CSS	$33,007,329	$31,159,750*
PEI	$17,017,881	$15,509,901
INN	$3,348,803	$3,685,506
WET	$215,000	$403,994
CFTN	$3,429,786	$6,525,959
Total Expenditures	$57,018,799	$57,285,110

- Posted amount was $30,959,750. $200,000 was added to budget during review period for match funding for a pre-trial felony mental health diversion program funded by Department of State Hospitals.

Next Steps

- **Complete minor staff edits**
  - Typos, formatting etc.
  - Minor correction: Described under Housing Coordination Services updated to reflect program enhancements
  - Minor correction: Update Housing Coordination budget to reflect updated positions
- **Incorporate feedback from 30-day Public Review and the Public Hearing**
  - Match funding for Pre-Trial Felony Mental Health Diversion Grant
- **Submit to Board of Supervisors for Review**
  - June 11, 2019 (*Anticipated)*

Questions / Comments

Audience questions and comments will be documented by staff and included in the summary of these proceedings.

Audience members are also invited to write down and submit any feedback or comments.

- Please submit to Isabel Espinosa at the end of this meeting

THANK YOU!

Send Further Comments to:

mhsacomments@sjcbhs.org

TORI VERBER SALAZAR
District Attorney, San Joaquin County

SCOTT A. FICHTNER
Assistant District Attorney

KRISTINE M. REED
Assistant District Attorney

DAVID J. DERKSEN
Chief Investigator

May 14, 2019

Tony Vartan, Director
San Joaquin County
Behavioral Health Services
1212 N. California St.
Stockton CA 95202

Subject: Need for additional MHSA funds to serve as match funding for a Forensic Assertive Community Treatment Team for Potential Incompetent to Stand Trial Patients

Dear Mr. Vartan:

I hope that you are able to set aside funding in next year's MHSA plan as match funding for a Forensic Assertive Community Treatment (FACT) team to provide services for seriously mentally ill offenders with the potential to be found incompetent to stand trial under Penal Code section 1370.

The District Attorney's office has applied as the lead entity in partnership with the Public Defender, Health Care Services, Behavioral Health and Correctional Health Services for Pre-Trial Felony Mental Health Diversion funding through the California Department of State Hospitals. As part of the draft plan for San Joaquin County's participation, we anticipate the need for a FACT team to provide wrap-around services for program participants. We anticipate approximately 16 enrollees in the program per year who would require FACT team services as a condition of participation. Therefore, I am requesting that the MHSA plan be augmented accordingly so that match funding for these services can be provided.

We anticipate that this program will begin sometime in the Fall of 2019 and continue for a minimum of three years. Thank you for your consideration of this request.

Sincerely,

Tori Verber Salazar
San Joaquin County
District Attorney

SAN JOAQUIN COUNTY PUBLIC DEFENDER

102 S. SAN JOAQUIN STREET, ROOM 1
POST OFFICE BOX 201030
STOCKTON, CALIFORNIA 95201-9030

TELEPHONE: (209) 468-2730
FAX: (209) 468-2267

MIRIAM LYELL
Public Defender

VICKIE DELPH
Assistant Public Defender

May 14, 2019

Tony Vartan, Director
San Joaquin County
Behavioral Health Services
1212 N. California St.
Stockton CA 95202

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Sincerely,

Miriam Lyell, Public Defender

Exhibit A

MHSA Component Project List and Budget

CSS	
FSP Programs	
1. Children and Youth FSP	3,721,767
2. Transitional Age Youth FSP	556,410
3. Adult FSP	4,951,318
4. Older Adult FSP	840,749
5. Community Corrections FSP	1,109,575
6. InSPIRE FSP	593,998
7. Intensive Adult FSP	1,500,000
8. Intensive Justice Response FSP	1,700,000
9. Housing Empowerment Services FSP	622,869
10. High-Risk Transition Team	720,000
11. Adult Residential Treatment Services	1,000,000
Non-FSP Programs	
12. Mental Health Outreach and Engagement	504,317
13. Mobile Crisis Support Team	863,826
14. Peer Navigation	300,000
15. Wellness Center	519,403
16. Project Based Housing	3,500,000
17. Employment Recovery Services	197,372
18. Community Behavioral intervention Services	510,261
19. Housing Coordination Services	2,163,429
20. Crisis Services Expansion	1,458,311
21. System Development Expansion	553,941
CSS Administration	3,233,204
Total CSS Program Estimated Expenditures	31,120,750

PEI	
Prevention Programs for Children, Youth & Families	
1. Skill Building for Parents and Guardians	479,102
2. Family Therapy for Children and Youth	785,291
3. Mentoring for Transitional Age Youth	860,305
Early Intervention Programs for Children and Youth	
4. Early Mental Health Services	1,530,987
5. School Based Interventions	2,914,259
6. Early Interventions to Treat Psychosis	314,133
Early intervention Programs for Adults and Older Adults	
7. Trauma Services for TAY, Adults and Older Adults	1,200,000
8. Recovery Services for Victims of Human Trafficking	712,332
9. Recovery Services for Nonviolent Offenders	472,706
10. Forensics Access and Engagement	600,000
Access and Linkage to Treatment Program	
11. Whole Person Care Project	383,009
Outreach for Increasing Recognition of the Early Signs of Mental Illness	
12. Increasing Recognition of Mental Illnesses	75,000
Stigma and Discrimination Reduction Program	
13. Information and Education Campaign	1,739,130
Suicide Prevention Program	
14. Suicide Prevention in Schools	592,248
15.Suicide Prevention Awareness Campaign	477,511
PEI Administration	2,199,225
PEI Assigned Funds	
Funds assigned to CalMHSA	174,663
Total PEI Program Estimated Expenditures	15,509,901

WET	
WET Programs	
1. Training and Technical Assistance	351,299
WET Administration	52,695
Total WET Program Estimated Expenditures	403,994

INN	
INN Programs	
1. Assessment and Respite Center	2,197,177
2. Progressive Housing	1,449,808
INN Administration	38,521
Total INN Program Estimated Expenditures	3,685,506

CFTN	
CFTN Programs - Capital Facilities Projects	
1. Residential Treatment Facilities for COD	2,434,786
2. Facility Renovations	1,935,173
3. Facility Repair and Upgrades	1,243,000
CFTN Programs - Technological Needs Projects	
4. Digital Health Management Solutions	913,000
CFTN Administration	0
Total CFTN Program Estimated Expenditures	6,525,959